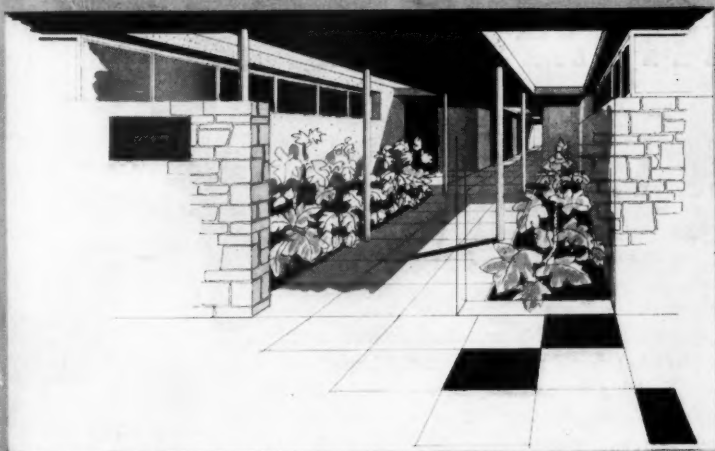


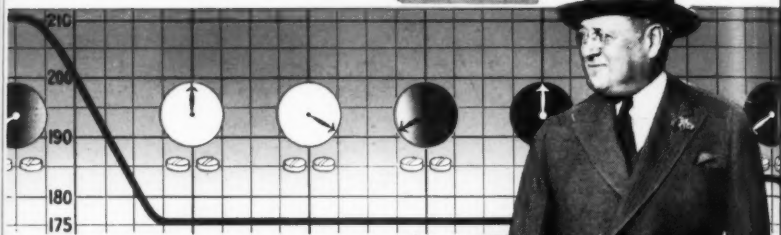
Medical Economics

DUPLICATE

JUNE



PAUL LASZLO DESIGNS A SEVEN-MAN PATIO-TYPE OFFICE • PAGE 48



A more normal life
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NITRANITOL

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Safe, Gradual, Prolonged Vasodilation

By maintaining the blood pressure at *safe levels over a prolonged period*, Nitranitol obviates many of the restraints generally placed upon the hypertensive—permitting a reasonably normal, useful life.

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Nitranitol contains $\frac{1}{2}$ gr. mannitol hexanitate in each scored tablet; dosage is 1 to 2 tablets every four hours. Available for prescription in bottles of 100 and 1000.



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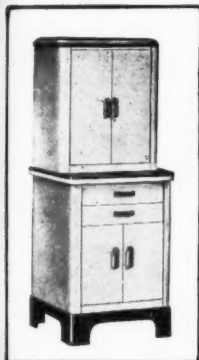
PHENOBARBITAL

combines $\frac{1}{4}$ gr. phenobarbital with $\frac{1}{2}$ gr. mannitol hexanitate. Scored tablets in bottles of 100 and 1000.



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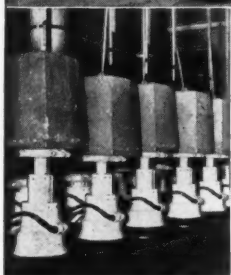
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350 POUNDS FOR 24 HOURS *is the routine test on the hydraulic mechanism of every Ritter chair. This is one of the precautions which assure you that your Ritter Chair will be right.*



EASE FOR YOUR PATIENTLESS STRAIN FOR YOU

- There are many good reasons that make the Ritter Motor Chair the best bargain in medical chair equipment. Not the least is its flexibility that enables you to work without strain or discomfort. It helps to set your patients at ease, secures maximum cooperation. In raising, lowering, and adjusting, its movements are smooth and gentle. For you, it's quick and easy to get patients into precisely the position you want. Adjustments are simple, made without forcing or strain; your dignity is maintained.
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The task of the physician today is greater than ever before. To help him in administering his many duties, it is essential that he use new, modern, efficient equipment.

Modernize your offices and equip them with time-saving and effective apparatus.

Doctors whose practice includes Obstetrics, Internal Medicine, Dermatology, Pediatrics or Orthopedics, will find frequent use for ultra-violet radiations.

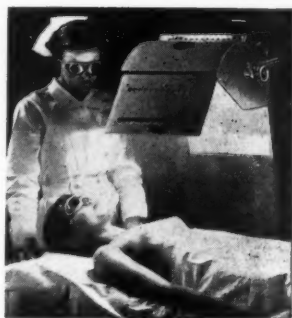
We recommend the new Hanovia Luxor Alpine Lamp which has a wide range of clinical usefulness.

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*which has a wide range
of clinical usefulness*



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Medical Economics

JUNE 1947

H. Sheridan Baketel, M.D., Editor-in-Chief. William Alan Richardson, Editor. Edmund R. Beckwith, Jr. and R. Cragin Lewis, Associate Editors. Lansing Chapman, Publisher. W. L. Chapman, Jr., Business Manager. R. M. Smith, Sales Manager.

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This salt substitute really tastes and looks like table salt but contains no sodium.

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For Your Convenience...

B-D NEEDLES
are now available
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● Yes it is true . . . B-D Yale Rustless needles are now available in ALL standard sizes . . . made from high quality hyperchrome stainless steel to give you many hours of added service. Yale Rustless needles can be supplied by your dealer in either Regular point in all standard sizes or Huber point in 27 gauge $\frac{3}{8}$ in. to 18 gauge 2 in.



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BALANCED Psychologically . . . by imparting immediately a sense of cool, clean, gratifying comfort, Tyree's restores the woman patient's subjective balance and makes her amenable to further curative treatment.

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BALANCED Therapeutically . . . finally, Tyree's value as a vaginal douche is positive, because it balances effectiveness with safety, avoids complications caused by caustic, irritating douching, while it acts as an effective treatment in vaginal infection. Try Tyree's the next time you prescribe a vaginal douche. Write for literature and professional samples.

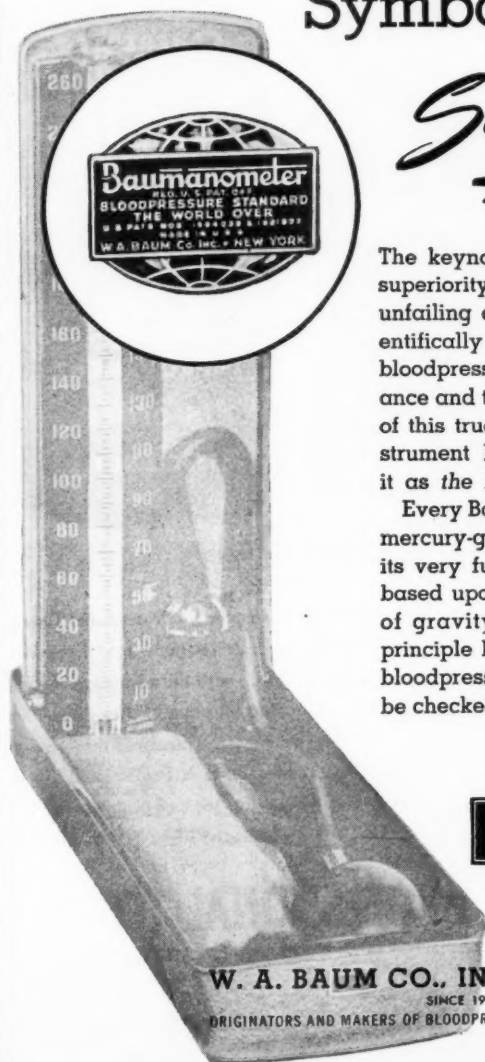
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J. S. TYREE, CHEMIST, INC., 15th and H Streets, N. E., Washington 2, D. C.

Manufacturers of **CYSTODYNE**, Tyree,
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The keynote of Baumanometer superiority is performance...the unfailing ability to provide scientifically accurate, trouble-free bloodpressure service. Performance and the inherent accuracy of this true mercury-gravity instrument logically recommend it as the instrument of choice.

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A Big
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Use Johnson & Johnson's *Disposable Professional Towels*.
 Made of MASSLINN* non-woven fabric. Professional Towels combine
 the softness and absorbency of cloth towels with the advantage of a low
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 of laundry service—just remove from package, use once and throw away!

- Besides being ideal for drying hands and face, Professional Towels
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Panorama

► "Specialty" boards for general practitioners, as set up in Indiana and Ohio, "are not the answer," says Chairman Roscoe L. Sensenich of the AMA Board of Trustees . . . Fourth largest of the medical-society-approved prepay plans, California Physicians Service reports it more than doubled enrollment last year . . . New invalid chair, battery powered, can travel ten m.p.h. forward, four m.p.h. in reverse, climb twenty-degree grades, turn on a dime . . . Native Son Kay Kyser, radio bandleader, taking leading part in plugging North Carolina's "Good Health Program," designed to bring adequate medical and hospital services "within an hour's ride of every family" . . . American Dental Association nearing goal of five dental specialty boards; specialists will be certified in oral surgery, orthodontia, pedodontia, periodontia, and prosthodontia.

► Industrial physicians must "shed their professional dignity" when dealing with factory workers, says Dr. Winslow S. Edgerly, Equitable Life Assurance Society, who believes, "We must step down from our pedestal and identify ourselves more closely with our fellow-workers" . . . Psychiatric case-finding "still in the horse and buggy stage," reports Dr. Robert H. Felix of the Public Health Service. PHS wants one out-patient mental hygiene clinic for every 100,000 population, says country now has only one-fifth the clinics needed . . . British Medical Journal notes widespread "drooping of the shoulder" among middle-aged and elderly Britons, blames it in part on "the many hours spent carrying shopping baskets in queues."

► Hospitals that limit staff membership to specialty board diplomates rapped by Connecticut State Medical Society resolution: similar resolutions passed by some specialty boards, including American Board of Urology . . . Drs. Elmer Henderson and Louis Bauer reporting this month to the AMA on their recent

junket to London where they took part in talks about setting up a world medical association . . . Of 250 brand-new graduates of the University of Minnesota School of Medicine queried by Dr. William A. O'Brien, Director of Post-graduate Medical Education, only one said he was going into general practice . . . Several medical associations pondering idea of restricting new private medical groups to geographical names only—*e.g.*, the Centerville Medical Group. Naming a group after its founder—*e.g.*, the Throckmorton Medical Group—said to give undue publicity to the physician named.

► Accusations of discrimination in medical school admissions leveled against five state-endowed medical schools in Pennsylvania; the five deans were summoned before a state senate committee . . . Plan to combine V.A. medical-hospital services with those of Army, now under consideration by budget bureau, is flayed by Veterans of Foreign Wars. Disabled veterans should be treated "as private citizens, and not under military control," says VFW . . . FBI admits ruefully that it's hip-deep in the diaper business; bureau has recovered so many shipments of stolen diapers that it can't store them all . . . "Full Circle," new Dodd, Mead novel, turns the fiction writer loose on the general practitioner. Book is about "a woman's love for two men, her husband and her family doctor."

► "Cocktails in excess, not in moderation" recommended for high blood-pressure cases; that's Dr. Louis W. Katz' tip to the American Foundation for High Blood Pressure . . . Diseased hearts of Chicago civic leaders who died of coronary thrombosis put on display by Chicago Heart Association; exhibit aims at encouraging preventive care . . . Leather dressing, used to waterproof G.I. boots in South Pacific, now on the market; one application said to waterproof a doctor's bag or shoes for the season.

► Babies' milk service delivers ready-made formulas in Massachusetts; service was started by two ex-Army nurses who make rounds in a refrigerated beach wagon. Subscribers don't even have to own a bottle . . . People who permit a nurse to work more than eight hours a day "are disregarding the best interests of the patient," says the AFL's Registered Nurses Guild, which has established a \$12.50 fee for eight hours of private duty nursing.

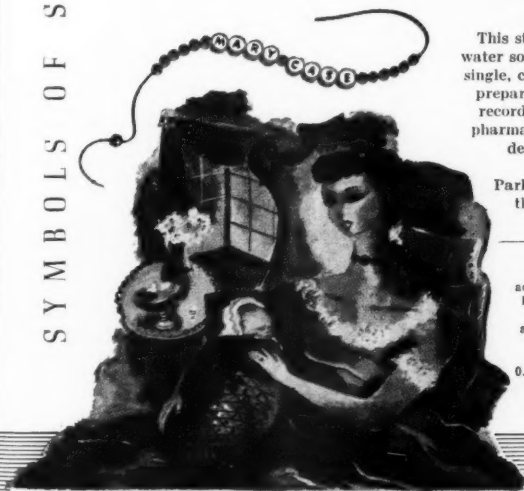
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Classically, mother love connotes protection; practically, ABDEC Drops help assure protection by complete vitamin supplementation. As simple and effective as they are essential, ABDEC Drops provide in each 0.6 cc. of a single liquid concentrate, eight vitamins in high potencies:

Vitamin A—5000 U.S.P. units; Vitamin D—1000 U.S.P. units
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 Vitamin B₁ (thiamine hydrochloride)—1.0 mg.
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This stable fusion of fat and water soluble vital factors in a single, convenient drop-dosage preparation—ABDEC Drops—records another in a series of pharmaceutical and therapeutic developments which have identified the mark of Parke-Davis as a symbol of therapeutic significance.

ABDEC Drops may be administered directly or may be added to formula or food without appreciably altering taste or appearance. Included in each package is a dropper graduated at 0.3 cc. (daily dose for infants under one year) and 0.6 cc. (daily dose for older children and adults).



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AMINO ACIDS?

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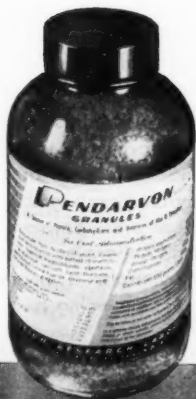
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Easy to serve hot at or between meals.

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STAND
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The familiar Rexall sign is a modern symbol of superior and dependable pharmacal service. More than 10,000 independent, reliable drug stores in this country display the Rexall symbol. It means that all Rexall drugs are laboratory-tested for purity, potency and uniformity under the rigid Rexall system of controls. It means superior pharmacal skill in compounding them.

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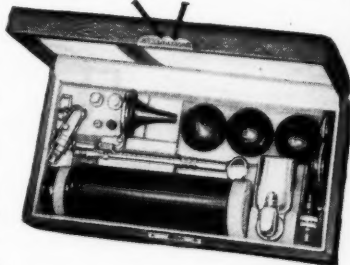
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National Diagnostic Sets are designed with but one thought in mind — that they shall be the finest and most complete that money can buy.

Life-time guarantee on Battery Handle casing against breakage under normal use. The tough, impact-resistant plastic coating molded over metal tubing assures rigidity and strength, plus a finish which will not chip, peel or crack.

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Double-disc Ophthalmoscope features housing guaranteed for life; optical crown glass lenses, 96 lens combinations, magnified illuminated numerals.



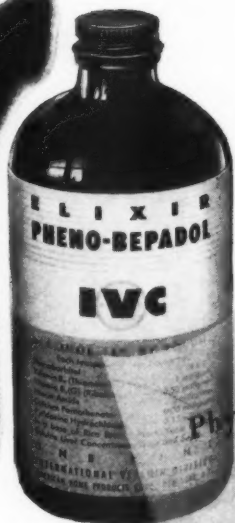
N2033 SPECIALISTS' SET includes Standard Otoscope (patented) with 6 specula, double-disc Ophthalmoscope with magnified illuminated numerals, large battery handle, illuminated (patented) tongue depressor holder, "All-Metal" transilluminator, laryngeal mirror and spare bulbs, in attractive plush-lined case

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Sedation and nutrition join hands in IVC's newest product, "Pheno-Bepadol." As a sedative, it is quick and efficient; the nutritive elements assure a minimum liability to side reactions. Particularly desirable in many functional digestive disturbances (such as neuroses, vomiting of pregnancy and diarrhea), "Pheno-Bepadol IVC" is particularly beneficial to patients suffering from simple insomnia, dull worry or apprehension. It helps to control nervous symptoms and produces the benefits of sedation. Available at most Druggists on your prescription only.

PHENO-BEPADOL FORMULA:
Each teaspoonful (4cc.) contains 1/4 grain Pheno-barbital, 1 mg. Thiamine HCl, 0.5 mg. Riboflavin, 5 mg. Niacin Amide, 0.3 mg. Calcium Pantothenate, 0.15 mg. Pyridoxine Hydrochloride. **DOSAGE:** "Pheno-Bepadol IVC" facilitates easy adjustment of dosage graduation to the intensity of reaction desired.

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**Treatment of
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Combined Poison Oak-Ivy Extract is —**

SIMPLIFIED—because it obviates the need for differential diagnosis between rhus venenata and toxicodendron dermatitis;

EFFECTIVE—because two or three injections usually provide prompt and marked relief of local symptoms (though each treatment set contains 5 doses of equal size); and

PAINLESS —because the injections cause minimal discomfort to patients when the extract is diluted just prior to treatment. • The extract is stable because absolute alcohol is used as solvent. Be ready to treat your cases of rhus dermatitis by ordering your supply of Combined Oak and Ivy Extract now —simple or double strength!

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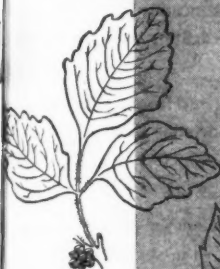
HOLLISTER-STIER LABORATORIES, Wilkinsburg, Pa.
Gentlemen: D-3

Please send full details about your Seasonal Treatment Oak-Ivy Extract.

Dr. _____
Please Print Clearly

Address _____

City _____ Zone _____ State _____



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WHEN ALL THE B's ARE

FOR A MORE RAPID RECOVERY from gastro-intestinal, dermatologic, cardiac, hematologic, nervous and other symptoms—traceable to a deficiency of vitamins of the B-Complex group—prominent clinicians favor the administration of whole vitamin B-Complex concentrates, fortified with large therapeutic doses of the fractions considered essential for human nutrition.^{1,2}

Such concentrates should be derived from a natural source—preferably yeast^{1,2,3}—to guarantee the availability of all unknown as well as known factors in easily assimilable form.

Allbee 'Robins'—the high potency B-vitamin preparation—has proved so effective in speeding nutritional rehabilitation because it has been formulated to conform to maximal specifications.

The complete B complex preparation

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and other
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plus these and other factors as found in dried primary yeast.

FORMULA: Each capsule contains

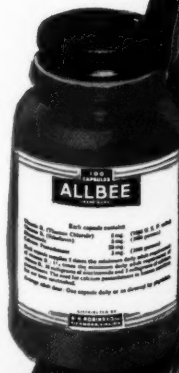
| | |
|----------------------------|---------|
| Thiamine | 15 mg. |
| Riboflavin | 10 mg. |
| Niacinamide | 50 mg. |
| Calcium Pantothenate | 10 mg. |
| Dried Primary Yeast..... | 292 mg. |

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Ethical Pharmaceuticals of Merit since 1878

1. Jolliffe, N.: J.A.M.A., 129:613, 1945
2. Spies, T.: J.A.M.A., 125:245, 1944
3. Ruskin, S. L.: Am. J. Dig. Dis., 13:110, 1946

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ALLBEE

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In treating Para-nasal Infection

Bacteriostatic Decongestion is the MEANS
Restoring Normal Function is the GOAL
with **ARGYROL** the Decongestant without
Rebound Action

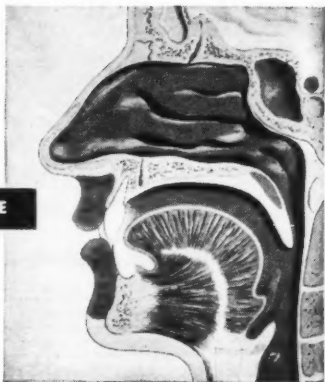
In recent literature emphasis is being given to the after effects that frequently follow use of vasoconstrictors because of their rebound action.

Such untoward results do not accompany the use of ARGYROL, the bacteriostatic decongestant that

AVOIDS THAT VICIOUS CIRCLE

When the physician uses ARGYROL he knows that he is contributing most to recovery through support of nature's own First Line of Defense.

The cleansing, demulcent, bacteriostatic action of ARGYROL is attained by its three-fold action.



Three-Fold Action of ARGYROL:

1. ARGYROL is decongestive, without irritation to the membrane, and without ciliary injury.
2. ARGYROL is powerfully bacteriostatic, yet is non-toxic to tissue.
3. ARGYROL stimulates secretion and cleanses, thereby enhancing Nature's own first line of defense.

Three-Fold Approach to Para-nasal Therapy:

1. The nasal meatus . . . by 20 per cent ARGYROL instillations through the nasolacrimal duct.
2. The nasal passages . . . with 10 per cent ARGYROL solution in drops.
3. The nasal cavities . . . with 10 per cent ARGYROL by nasal tamponage.

ARGYROL *the Physiologic*
Anti-infective with broad, sustained action



Made only
by the **A. C. BARNES COMPANY, NEW BRUNSWICK, N. J.**
ARGYROL is a registered trade mark, the property of A. C. Barnes Co.

Speaking Frankly

Windfall

Re your mention of unforgettable patients:

One I won't forget is Mrs. G.D.C. When she died, she left me \$5,500.
M.D., Maine

Embroidery

I believe a statement in Doctor Davidson's "Writing for Medical Journals" is incorrect. He says "No degree outranks an M.D. . . ." Actually, the American M.D. is the equivalent of the English M.B. and, like it, is only a bachelor's degree. Post-graduate degrees like Master (or Doctor) of Medical Science are certainly higher than an M.D.

M.D., M. Sc. (Med.)
Philadelphia, Pa.

Historically, the M.D. parallels the baccalaureate degree. But today 85 per cent of the students who enter medical school already have a B.A. or B.S. If the college system in medicine conformed with the system followed in other sciences, an M.S. would be awarded after the first two years, a doctorate after the second two. Progress through medical school would parallel progress

through graduate work in, say, chemistry, leading to an M.S. after two years, a Ph.D. or D.Sc. after two more. It may be seen, therefore, that the Ph.D., D.Sc., and M.D. represent equivalent training.

The M.Sc. and the Doctor of Medical Science which some schools offer represent a superstructure for which we have no place in our neat three-level system. They are analagous to board diplomas in the specialties or to fellowship in a college of surgeons. Since editorial practice frowns on featuring these honors when listing the author on an article, it is also proper to delete analogous degrees.

Henry A. Davidson, M.D.
Newark, N.J.

Needle

Does "M.D., California" suggest as a panacea for the shortage of psychiatrists that the American board issue certificates at random to all who apply? He dismisses the examination as a "hasty, lay oral." That oral is an eight-hour grind covering such related subjects as psychopathology, physiology, dynamics, neurology, psychiatry,

[PLEASE TURN TO PAGE 20]



Air Travel Easy with Evenflo Nurseries

TWA Hostess Elsie Corbett is shown feeding a baby in flight with an Evenflo Nurser. Other air lines, too, have these modern, easy-to-use Evenflo Nurseries in their baby kits to make travel convenient for mothers with babies. Quite often mothers prepare their own formulas, then fill and seal enough Evenflo Nurseries for the entire trip. Thus on trains, planes or buses, they are ready for feeding simply by placing the nipple upright.

Doctors and nurses praise Evenflo's valve-action nipple that permits babies to nurse in comfort and finish their bottles better.

Evenflo Units come in regular 8 oz. and new 4 oz. hospital sizes. Parts are interchangeable. Both sizes are 25c, parts 10c each.



Twin air valves relieve vacuum, prevent collapse.



Evenflo
America's
Most Popular Nurser

pathology, and roentgenology. When the examiners have finished with the candidate, they don't have to guess whether he's qualified.

This examination is only part of the procedure. Qualifications must be presented and checked. Certified diplomates in the applicant's community are solicited for confidential reports.

After five years of military service, I know that no matter what the specialty, you can tell the skilled, certified specialist from the self-appointed, uncertified genius nine times out of ten.

James A. Brussel, M.D.
Assistant Director
Willard State Hospital
Willard, N.Y.

P.G.

A year or so ago, I read your article about a special plan under which small-town doctors were taking post-graduate training. A medical school had set up a medical center where country doctors went for intensive study. Can you tell me where that medical center is?

John W. Morris, M.D.,
Morehead City, N.C.

At St. Elizabeth's Hospital, Lafayette, Ind.

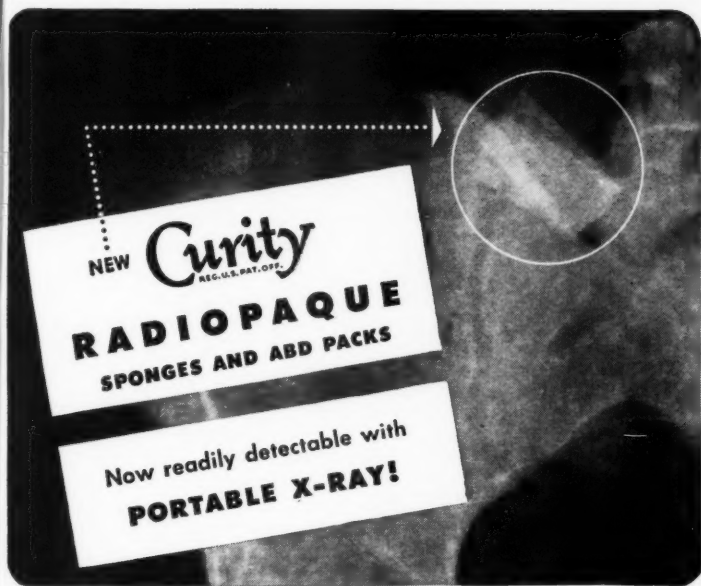
Bub

How do you get people to call you "Doctor"? I mean when you've got a perfectly good M.D. I've come back to practice in my home town, and everyone calls me Bobby. I'd even settle for Robert.

M.D., Idaho

[PLEASE TURN TO PAGE 22]

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NEW **Curity**
REG. U.S. PAT. OFF.

RADIOPAQUE
 SPONGES AND ABD PACKS

Now readily detectable with
PORTABLE X-RAY!

Curity Radiopaque Sponge (circled) placed over abdomen near McBurney's point. Note contrast even to bone shadow. Patient data: Normal, healthy male, aged 22; weight, 73 kg.; height, 173 cm.

The new Curity Radiopaque Sponges and ABD Packs now can be clearly and definitely identified with portable X-ray equipment—with or without a Bucky-Potter diaphragm. The barium insert remains as unmistakable as ever (see roentgenogram, above), but the improvement in this element extends the scope of use for Curity Radiopaque Sponges. Now, the same consistently good results are assured with either portable or fixed X-ray equipment.

Thoroughly Tested

Before release, the improved sponges and packs were tested under the most adverse condi-

tions. A leading roentgenologist selected the oldest portable equipment available in several hospitals—machines in use 6 to 10 years, all without a Bucky-Potter diaphragm. Actual hospital patients (weight range 115-172 lbs.) were subjects. Sponges were placed at maximum distances from the X-ray plate, in positions where penetration and detection would be most difficult.

In every case and in every negative, the improved Curity Radiopaque Sponge element was readily and plainly seen. Try Curity Radiopaque Sponges and ABD Packs and see for yourself!

Products of

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Division of The Kendall Company, Chicago 16

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WHETHER MERELY SEDATION *is Needed or Hypnosis*

The need for continuous mild sedation arises frequently. Emotional upheavals, apprehension, transient emotional shock, and increased psychomotor tension all call for sedative medication to tide the patient over until the underlying cause can be corrected. For this purpose, Bromidia dependably produces the effect desired. Containing three sedatives of well-established efficacy—chloral hydrate, potassium bromide, and hyoscyamus—Bromidia eases nervous tension and leads to welcome relaxation and emotional calm. One-half to 1 dram t.i.d. usually suffices. Should a hypnotic influence be required, 2 to 3 drams produce refreshing sleep of 6 to 8 hours duration, free from post-sleep drowsiness or hangover... Bromidia is available on prescription through all pharmacies.

BATTLE & CO.

4026 Olive St.

St. Louis 8, Mo.

BROMIDIA
(BATTLE)

Disaffection

The public today seems less friendly to the medical profession than formerly, judging from reports of our legislative committee. Legislators admire the scientific achievements of the profession, but they hear too many gripes from the people back home. This may be due in part to the scarcity of physicians during the war and to the fact that those at home were overworked and, at times, not too considerate.

Much of the trouble is caused by loss of intimate contact with the family doctor. Not long ago, I asked a family head, "Who is your family physician?" He proceeded to list six specialists whom he saw occasionally. Plainly there was no personal touch in that family's medical care.

Over-specialization may produce more highly skilled medical care but the passing of the family physician is lessening medicine's effectiveness and injuring its esteem.

Cleon A. Nafe, M.D., President
Indiana State Medical Assn.
Indianapolis, Ind.

Problem

What can an elderly physician and his wife do after he retires? After fifty-five years in practice, my husband enjoys excellent health, sight, and hearing. We want more leisure, but we want also to do something useful.

Since 1902, my husband has practiced in California and I have assisted him as an R.N. We're moderately well off. I had hoped we



You know the importance of the psychological effect of tasty food!

When the patient is recovering from an illness, what can raise the spirits or help to speed the convalescence more than foods that *look* and *taste* delicious?

That's why Knox Gelatine is such a joy. It's so easy to make tempting dishes that tempt even a flagging appetite. So many different recipes to choose from: so many of them made with real fruits or real vegetables, flavored with

their good, natural juices. Patients are able not only to enjoy the fresh flavors but to benefit by the natural vitamins.

Knox Gelatine, unlike flavored gelatine powders which are $\frac{7}{8}$ sugar, artificially flavored and acidified, is all protein, contains no sugar.

FOR FREE BOOKLET, "Feeding the Patient," write to Knox Gelatine, Dept. 448, Johnstown, N. Y.

KNOX GELATINE

ALL PROTEIN, NO SUGAR



To accomplish a soothing, subjective sensation of eye comfort

DRUG SOLUTIONS introduced into the conjunctival sac have their effect modified by a number of factors. Among these factors, the following three must be considered:

1. Immediate dilution of the solution by tears present in the sac.
2. Precipitation of the drug substance present in the tears or conjunctival sac—or its chemical union with such substance. This is especially important in the presence of highly albuminous secretion, as may be seen by the white precipitate of silver albuminate formed when silver nitrate is applied to the lids covered with a purulent secretion. Such combination, of course, renders most of the drug inactive.

3. Most important of all factors is the reaction of tissue and tears with the solutions employed. It has been shown that the reaction of commonly used collyria is the chief factor in irritation felt when they are introduced into the sac. Reaction of solutions is far more important than their osmotic pressure. Normal conjunctival secretion has a reaction of 7.2 to 7.4. In certain forms of chronic irritation or conjunctivitis, the pH varies from 6.8 to 6.9. Mere installation of an alkaline collyrium is sufficient to allay symptoms of irritation.

A simple form of buffer solution is an ideal medium for eye drops. An alkaline solution is less irritating and is a suitable medium for certain drugs. An alkaline buffer solution alone is a non-irritating collyrium suitable for cleansing. Because of its proper pH, it reduces shock and increases effectiveness.

Murine, a modern isotonic collyrium, meets every one of the above desiderata. In addition, Murine is isotonic with the tears and is a truly buffered solution. Combined in Murine's formula are the following ingredients: Potassium Bicarbonate, Potassium Borate, Boric Acid, Berberine Hydrochloride, Glycerine, Hydrastine Hydrochloride, "Merthiolate" (Sodium Ethyl Mercuri Thiosalicylate, Lilly). .001%, combined with sterilized water. This all makes for a soothing, cleansing, and still uniquely therapeutically effective preparation for minor irritations of the eye.

THE MURINE COMPANY, Inc.
660 NORTH WABASH AVE., CHICAGO 11

might be able to go to Europe (my husband speaks French and German), adopt some children, and bring them back. I'm told, however, this wouldn't be possible for us at our age. We also thought of going into the Deep South, where physicians are few; but my husband doesn't drive a car.

What can your readers suggest? If we do nothing, we're bound to be disconsolate. Our health and happiness are due in large measure to our interest in people and in their problems.

M.D.'s Wife, California
MEDICAL ECONOMICS will forward suggestions.

Courtesy

When I was in medical school one of the professors removed my appendix. After the operation I asked what I owed him. "Young man," he said, "don't insult me."

I never saw this code broken until recently. I had to undergo an emergency operation in Florida. "I am going to charge you," the surgeon said. "If you were still in practice or were a resident of this area, it would be different." I agreed; but living on the reduced income of a retired physician, as I clearly was, I expected a nominal charge. The fee was just about the maximum.

I understand why physicians in a resort state might charge non-resident M.D.'s. But I see no justification for the asking the maximum fees from one's fellow doctors.

M.D., California

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If the patient rebels at liver or yeast . . .

For the many Vitamin B Complex deficient patients who rebel at the taste, odor, aftertaste and viscosity of liquid B Complex preparations derived from liver or yeast, ESKAY'S PENTAPLEX is the therapy of choice.

ESKAY'S PENTAPLEX—because it is an elixir compounded from five important factors of the B Complex *in their crystalline forms*—is outstandingly palatable. The most difficult patient will not tire of it, even with continued use.

ESKAY'S PENTAPLEX, furthermore, is easily tolerated, and free from the disadvantages of yeast—which often gives rise to gastro-intestinal distress, and even, in some instances, to severe allergic reactions. *Smith, Kline & French Laboratories, Philadelphia, Pa.*

ESKAY'S PENTAPLEX makes B Complex therapy palatable

NOW *Eliminate Unpleasant Odors* **ELECTRONICALLY**

Now—ELECTRONICS provides a new scientific way to produce nascent oxygen from ultra-violet to eliminate and reduce unpleasant odors from doctors' offices, reception and treatment rooms, hospitals, sick rooms, homes, etc. Gives air a mountain-fresh quality.....

Electronic **AIR FRESHENER** *by Burton*

Here's a thing of beauty as well as of great benefit. Elegant cream white baked enamel; polished aluminum and chrome trim. For wall or desk. No moving parts, care or refills. See your dealer, or write us.



for WALL or DESK

PRICE
\$24⁷⁵
(A. C. ONLY)

**NO CHEMICALS . . . NO WICKS
NO WAFERS . . . NO REFILLS
JUST PLUG-IN — FLIP THE SWITCH
AND IT GOES TO WORK!**



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what bulk more gentle than liquid?

Modern scientific practice concedes the necessity for bulk in the physiologic mechanism of evacuation.

The natural stimulus for the peristaltic reflex is distention of the bowel lumen, not mucosal irritation.

SAL HEPATICA, by simple osmosis, increases the bowel's liquid content; the fecal residue is softened; and gentle fluid bulk is the result.

The degree of activity of this balanced saline is easily controlled by dosage.

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LAXATIVE

CATHARTIC

For gentle yet speedy relief, prescribe

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A Professional Product of BRISTOL-MYERS COMPANY

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THERAPEUTIC* B COMPLEX WITH C

HARROWER

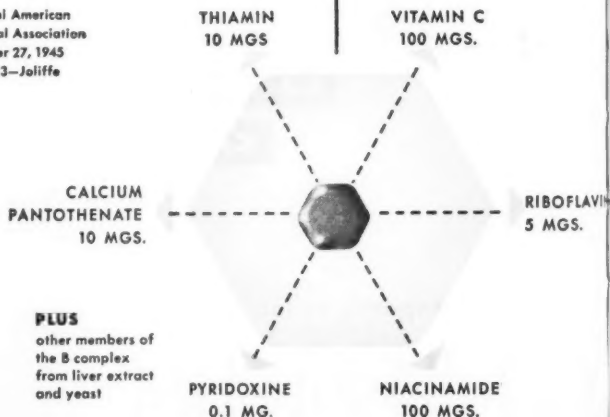
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All of the water-soluble vitamins
are contained in each
balanced Enforbec **THERAPEUTIC***
B Complex and vitamin C tablet.

ECONOMICAL
THERAPEUTIC*
DOSAGE AGREEABLE
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*Journal American
Medical Association
October 27, 1945
129:613—Joliffe



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Big Hit With Babies— Heinz Strained Chicken Soup

Rich with Tender Chicken and Golden Egg Noodles



BABIES like the other Heinz Strained Soups—Beef Broth with Beef and Barley; and Beef and Liver Soup! They're outstanding for flavor, color and texture.

YOU'LL find that the babies in your care really enjoy Heinz Strained Chicken Soup! All the goodness of old-time chicken soup is captured in this favorite especially adapted for babies! Made from tender, plump chickens, rich cream, golden egg noodles and choice vegetables, it's also a good source of riboflavin. Recommend Heinz Strained Chicken Soup for the enjoyment and nourishment of your youngest patients!

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A 78-Year Reputation Backs the
Complete Line of

Heinz Baby Foods

CEREALS • MEATS • VEGETABLES
FRUITS • DESSERTS



57

NIA

Doctor, will you try?

Hemo compared with minimum daily adult requirements*

| | Minimum daily adult requirements | Two servings** of Hemo and 16 fluid ounces of milk (2 glasses) | Two servings** of Hemo |
|------------------------|----------------------------------|--|------------------------|
| Vitamin A | 4000 U.S.P. units | 4900 | 4000 |
| Vitamin B ₁ | 333 U.S.P. units | 400 | 333 |
| Vitamin B ₂ | 2 milligrams | 3 | 2 |
| Vitamin D | 400 U.S.P. units | 410 | 400 |
| Niacin amide | Not yet established | 10.3 mg. | 10 mg. |
| Iron | 10 milligrams | 15.7 | 14.7 |
| Calcium | 750 milligrams | 950 | 376 |
| Phosphorus | 750 milligrams | 750 | 288 |

* As set by Federal Security Administrator under authority of the Federal Food, Drug and Cosmetic Act. (Hemo does not contain Vitamin C.)

** Two servings equal four teaspoonfuls Hemo-1.33 oz. Powder Hemo or 1.86 oz. Liquid Hemo.

24 glasses on us?

AS THAT chart on the left clearly indicates, Hemo[†] provides more than an adequate daily supply of essential vitamins and minerals.

But there is another important factor—not shown on the chart—which we think adds considerable enjoyment to Hemo's value as a food drink.

And that is Hemo's unusually rich, milk-chocolatey flavor. This is why we suggest you try Hemo yourself—at our expense. We think you'll agree that, hot or cold, Hemo makes a highly palatable, as well as a highly nutritious, food drink.

A twenty-four-serving can of Hemo is available upon request. Write to The Borden Company, Dept., ME-67, 350 Madison Avenue, New York 17, N. Y.

Borden's **Hemo**



POWDER AND LIQUID

IF IT'S BORDEN'S, IT'S GOT TO BE GOOD!

Available in all drug and grocery stores!

Reg. U. S. Pat. Off.

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Now...

FOR GREATER EASE OF ADMINISTRATION

Parenamine

Parenteral Amino Acids Stearns

IS SUPPLIED IN

6% sterile solution

- In Convenient One-Liter Bottles
- Ready For Immediate Use

An improved acid hydrolysate of casein, fortified with *dl*-tryptophane, *dl*-methionine and glycine, PARENAMINE 6% is a complete mixture of all the amino acids essential for humans plus other amino acids native to casein.

Sterile, pyrogen-free non-allergenic, pH 5.5, PARENAMINE 6% has an exceptionally low ash (sodium ion) content and is virtually chloride-free. Clinical studies indicate that thrombosis rarely occurs.

FOR USE whenever dietary measures are inadequate for maintaining an optimal protein nutritional state.

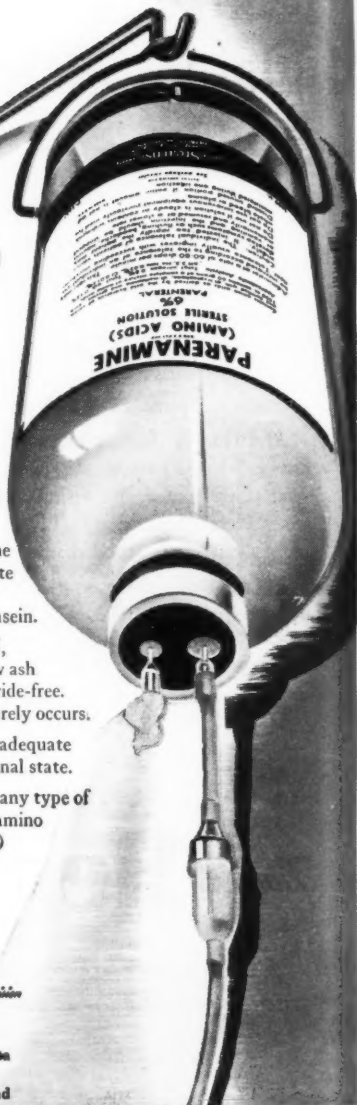
SUPPLIED in one-liter bottles, adaptable to any type of intravenous delivery set-up . . . 60 Gm. of amino acids (the average adult daily requirement) in 1000 cc. of distilled water.

PARENAMINE 15%—acid hydrolysate of casein fortified with *dl*-tryptophane—continues to be available in 100 cc. bottles.

Frederick **Stearns** & Company Division

DETROIT 31, MICHIGAN

New York Kansas City San Francisco Atlanta
Windsor, Ontario
Sydney, Australia Auckland, New Zealand



Trade-Mark PARENAMINE Reg. U. S. Pat. Off.

Sidelights

Is the medical profession "split wide open" over compulsory health insurance. That's what some lay writers in favor of state medicine would have us believe. They point to the fuss stirred up by organizations headed by Dr. Ernst P. Boas and Dr. Channing Frothingham as evidence of how medicine's ranks are shot with dissension.

Actually, the public might be interested in knowing that the ranks of doctors plumping for compulsion are slim indeed. At last reports the three most active such groups, the Physicians Forum, the Committee for the Nation's Health, and the Committee of Physicians for the Improvement of Medical Care, had about 4,000 members among them. That's slightly more than 2 per cent of all physicians in the country.

If more of our patients knew that, it's possible they'd judge medical opinions on state medicine by their weight rather than by the noise their sponsors make.



Our roving reporter submits a jaundiced memo on the reading matter in doctors' waiting rooms. "Most M.D.'s take a dim view of

the reading public," he complains. "Tattered copies of *Life*, *Hygeia*, and *The National Geographic* continue to be reception room staples. After several encounters with the same 1945 issue of *House & Garden*, I would have paid cash gladly for a current copy of *Spicy Railroad Stories*."

Our road man winds up, though, with evidence that appears to hang the blame on patients. "What they don't walk off with, they mutilate," one M.D. told him sadly. A G.P. whose waiting room was graced solely by a spreading fern added this dour note: "Seed catalogues would furnish splendid reading for waiting patients. And last year's phone book—on a chain, of course—would be God's gift."



The investors of Boston are anything but wild and capricious. Nevertheless, no cries of protest were heard when the financial editor of *The Boston Herald* wrote recently that "nobody ever makes money without taking chances."

We know several young colleagues who might take note of this wink at speculation. The budding



Brilliant Therapy in Pharyngitis

CĒPACOL

ALKALINE GERMICIDAL SOLUTION

- powerful non-mercurial antiseptic
- mucin-clearing detergent
- pleasant, soothing alkaline solution

The powerful bactericidal action and foaming detergency of Cēpacol, together with its freedom from toxicity or irritation in clinical use, recommend this soothing alkaline solution for infections and inflammations of the pharyngeal mucous membrane.

Cēpacol is pleasant and refreshing when used as spray or gargle.

PINTS AND GALLONS

Trademark "Cēpacol"

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MERRELL

1828

THE WM. S. MERRELL COMPANY
CINCINNATI, U. S. A.

physician, putting his money on his future, isn't exactly playing the longest shot to win. Yet we've seen more than one youthful M.D. go too far in trying to cut down his risk. Perhaps he starts with too little equipment in an office that's not geared for expansion. In the end, he finds that excessive caution has driven away the practice he might otherwise have had.

Like the man who hid his money in a beer bottle, the young physician may wind up the victim of his excellent liquid condition.



"Call this a fanciful fable, if you like," says *Cosmopolitan Magazine* in introducing Frederick Wakeman's story of the great doctors' strike of 1953. "Or call it savage satire."

We prefer to call it just plain silly.

In "Doctor Wilder's Dilemma," inflation has the country in its grip. The Government has slapped a ceiling on medical fees. Result: "Doctors, who formerly occupied a high place in the economy, are now among the lowliest of the poor." Doctor Wilder, for example, has had to sell his car, move to a three-room flat, and live on a steady diet of fish.

So the doctors strike. A mass meeting makes the rafters ring with this pledge: "I will not serve a single patient until our just and equitable demands are met, so help me God!" What's more, Mr. Wakeman's M.D.'s make it stick. Doctor



"No wonder! His doctor gave him D-P-T★"

Pick *any* feature of Cutter D-P-T — and you'll find a reason why this combined vaccine gives better protection!

Human blood, used for growing pertussis organisms, not only assures high antigenicity of organisms—but also rules out the danger of anaphylactic shock due to heterologous animal protein.

Extreme purification of diphtheria and tetanus toxoids yields well over one human dose each, per cc.

Concentration of toxoids—plus 40 billion Phase I pertussis organisms per cc.—permits a dosage schedule with D-P-T of only 0.5 cc., 1 cc., 1 cc.

Cutter also makes D-P-T (*Alhydrox*), which offers further advantages: It provides higher immunity levels than alum precipitated vaccines. Cuts side reactions to a minimum. Lessens pain on injection because of its more physiologically normal pH.

Choose D-P-T—Plain or Alhydrox—you'll find it advantageous in your practice.

★ *Cutter's brand of combined diphtheria, pertussis and tetanus antigens.*

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For your "anxious-to-do-right" parents, Cutter offers an informative new booklet—"How to Prevent Diseases of Children." Write us for the gift copies you'll need.

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Fine Biologicals and
Pharmaceutical Specialties

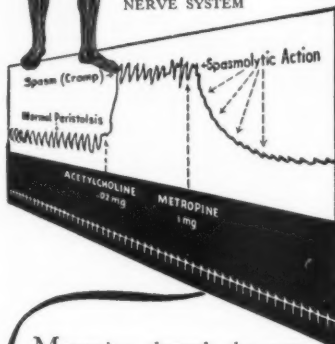
METROPINE

REG. U.S. PAT. OFF.
METHYL ATROPINE NITRATE (STRASENBURGH)



A
**DEPENDABLE
SPASMOLYTIC**

NERVE SYSTEM



Metropine, through the parasympathetic system, provides maximum spasmolytic action with minimum toxicity. The margin of safety between the therapeutically effective dose and that causing reactions is very large. Consequently Metropine is the choice wherever routine antispasmodic treatment is indicated. Further information will be supplied on request for folder MB.



R.J. **STRASENBURGH Co.**

PHARMACEUTICAL CHEMISTS SINCE 1899

ROCHESTER 4, NEW YORK

Wilder walks out on a patient shrieking in agony. His wife takes his place, returns covered with blood to announce she's botched the job. Then, mercifully, the strike ends. The doctors win every point.

What makes this pot-boiler particularly foolish is the casual credence it gives to the notion of doctors striking against the sick public. Strike against a Government system of medical care? Physicians abroad have done it, and it's been talked of here. But nowhere has such a strike diminished medical service to the public. Nowhere has the medical profession turned its back on sick patients. Nor is it likely to in 1953 or in 2053, God and the atom willing.



A patient we know is furious because her physician claims *she's* color-blind. "He was wearing one blue sock and one green," she reports. "The rest of his costume consisted of a rumpled, brown-striped suit, a gray-striped shirt, an orange-striped tie with magenta circles, and black shoes. Really!"

The only explanation we can offer, barring utter sartorial slackness, is that the good doctor suffers from that occupational hazard, dressing in the dark. But perhaps even those who must dress by Braille can arrange their wardrobes more symbolically than in this case.

Meanwhile, our shockability on the subject of clothes is zero. We doubt that anyone will go the Merchant Tailors and Designers Asso-

NOW . . . Faster Recovery of Sterilizing Temperature

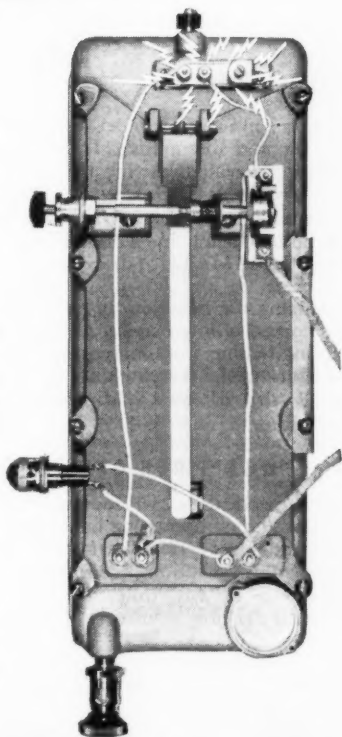
PELTON Presents
*a truly super-automatic
sterilizer . . . a new war-
time development*

PELTON'S new thermostatic device means faster recovery of sterilizing temperature. When you replenish the water supply in the boiler, the thermostat immediately re-engages the high heating element. The result is quicker boiling.

You will appreciate Pelton's new speed and efficiency. It saves valuable time now being wasted by a sluggish recovery of sterilizing temperature.

This new thermostat is standard equipment on all Pelton automatic instrument sterilizers.* Ask your dealer for a demonstration.

**For AC operation*



PELTON

PROFESSIONAL EQUIPMENT
SINCE 1900

THE PELTON & CRANE CO., DETROIT 2, MICH.

PRURITUS

...due to Insect Bites
by Poisoning • Sunburn
Localized Vesicular Areas



CALAMATUM

(NASON'S)

affords immediate relief for the itching and discomfort of skin affections prevalent during the summer months. It is a *cream* embodying Calamine with Zinc Oxide and Campho-Phenol in a non-greasy base. CALAMATUM dries at once, adhering to the lesion and thus localizing the infection by preventing spread of any exudate. By alleviating itching with consequent desire for relief by scratching, it reduces the dangers of secondary infection.

WON'T RUB OFF

Easy application without messy liquids and embarrassing bandages, and the handy tube instead of a fragile bottle of lotion encourage applications at any time. In 2-oz. tubes at druggist or direct.

TAILBY-NASON COMPANY

Kendall Sq. Station • BOSTON 42, MASS.



ciation one better. For among the ensembles recommended recently by that organization are "canary-yellow dinner jackets to be worn with brown trousers, an ecru shirt, and waffle-cut gold studs."

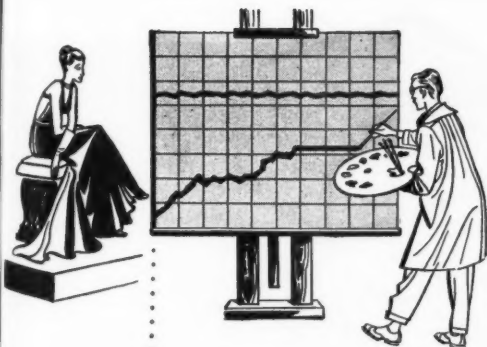


A good example of how *not* to stifle socialized medicine has been making the rounds of the popular magazines. It's the story of the British physician who announced, on entering his office, "Those patients who have headaches, please stand." After dealing out identical prescriptions, he repeated the procedure for patients with coughs.

The tale was told first by a Chicago physician who testified last year before a Senate committee. It got into the Journal AMA, then was picked up by the lay press. This spring it bobbed up in Reader's Digest under the title "Socialized Medicine—Bad Medicine for You!"

Trouble is, the story was branded as a "gross libel" by the secretary of the British Medical Association soon after it got into print. The first person to tell it got his facts and fiction badly mixed, he said; for "such methods are never adopted by British insurance practitioners." Since this blast elicited no substantiating facts and figures from the narrator, the only possible conclusion is that medicine has a turkey on its hands.

All of which takes us back to a point made here before. Let's examine the charges we throw against socialized medicine *before* we throw 'em.



The Picture of Marian Gray

You may know her—the secondary anemia patient who improves to a point below normal on iron therapy alone and then fails to show further progress. Such cases, which are far from rare, often may benefit from the discovery by University of Wisconsin scientists that maximum hemoglobin regeneration requires copper to serve as a metabolic activator for the iron. Abbott's Cofron Elixir is based on that discovery. It supplies copper and iron in the therapeutic ratio found most effective by the research workers: 1 part copper to 25 parts iron. In addition, it contains liver concentrate as a source of vitamin B complex factors. • Cofron Elixir is designed for the treatment of nutritional and other secondary anemias, for anemias accompanying prolonged illness, and for general use as a hematinic. As it is a palatable liquid, it is especially suitable for children and others who prefer liquid to capsules. • Cofron with Liver Concentrate in Capsules is offered for the treatment of more severe secondary anemias. Cofron Elixir is available through your pharmacy in 12-fluidounce and 1-gallon bottles. Cofron with Liver Concentrate in Capsules is stocked in bottles of 100, 500 and 1000 capsules.

ABBOTT LABORATORIES, North Chicago, Illinois.

Cofron

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→ *Elixir*

→ *with Liver Concentrate* IN CAPSULES

Manufactured under license from the University of Wisconsin Alumni Research Foundation



Announcing **DEBAMIN**

... a highly palatable protein hydrolysate, fortified with B-complex vitamins

Here is a new means of amino acid therapy that will find little or no patient resistance.

In an entirely new way, DEBAMIN has overcome the unpleasant flavor and undesirable acidity of ordinary casein or yeast hydrolysates. Added to a cup of boiling water, each dose produces a cup of delicious broth of approximately neutral pH.

DEBAMIN helps to overcome protein starvation if prescribed in nutritional edema, hypochromic anemia, hepatic disorders, pregnancy and lactation, postoperative surgery, burns, ulcers, renal diseases and whenever added protein hydrolysate treatment is indicated.

Packaged in a box of 35 individual moisture-proof pliofilm envelopes containing 10 grams each, DEBAMIN lends itself to individual dosage requirements.

Write for free illustrative sample and booklet "AMINO ACID THERAPY" for complete information.

Five doses of DEBAMIN per day will supply...

37.5 Gm. Protein Hydrolysates
5.85 mg. Vitamin B₁ (Thiamine)
2.05 mg. Vitamin B₂ (Riboflavin)
10.0 mg. Niacinamide
1.0 mg. Vitamin B₆ (Pyridoxine)
10.0 mg. Calcium Pantothenate



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Editorial

Chain Reaction

Our medical schools have been supported by a rich uncle for the last five years. During the war, 80 per cent of all medical schooling bills were paid by Uncle Sam. Last year, the G.I. Bill of Rights tapped his wallet to pay the way for 60 per cent of new students.

But what about tomorrow?

Government spending has only served to put off a day that medical educators have long dreaded. While tuition charges are now 50 per cent higher than in 1931, they account for little more than one fourth the average medical school's income. Rising standards of medical education have also meant rising costs. Unless our medical schools continue to keep on the right side of their rich uncle (or find another one) either standards must go down or the schools must put more of a bite on their students.

Making students pay more means that more of them must come from higher-income families—in itself a drawback. It also means that when these men graduate, they will set higher fees to recoup their higher educational investment. Raised fees will, in turn, lead to public resentment—and that means support for

the move to nationalize medicine.

How can medical schools meet their costs without commandeering the student's bankroll. Four ways have been suggested: They can cut back the number of new students admitted. They can seek heavier endowment. They can treat patients on a fee-for-service basis. They can accept Government subsidies.

Some schools have already reduced their war-time admissions as much as 25 per cent. But most costs borne by the schools represent overhead. If standards are kept where they are, or raised, cutbacks in the number of students will have little effect.

Heavier endowment is a worthy goal but an impracticable one for two reasons: (1) High Federal income taxes leave little money over for such use and (2) low interest rates make endowments far less productive than they used to be.

Treating patients for pay puts medical schools in the position of competing with their own graduates. What's more, it cannot be expected to take up all the financial slack anyway.

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That leaves the subsidy as the most-discussed means to the desired end.

Many medical educators think Government aid can be continued and expanded without getting bureaucratic fingers into the medical pie. Others are not so sure. Yet with half our medical schools operating below safe financial limits, the interest being shown in Government subsidies is not hard to understand.

Tax funds now provide 20 per cent of U.S. medical schools' total income. Last year, AMA delegates gave their nod to Federal grants-in-aid for medical education, if organized and administered soundly. AMA officers have suggested Federal help in providing scholar-

ships and loans for students who are both competent and needy. Even state tax funds have in some cases been made available to private medical schools.

The important thing is not *whether* government should help, but *how*.

No matter what method is employed, the public must be shown the need of supporting medical education. The people can hardly be expected to pay the freight unless they are given good reasons for doing so.

Neglect of this job invites the chain reaction from higher tuition to higher fees to patient resentment to support for state medicine. —H. SHERIDAN BAKETEL, M.D.



"THE ONE BEHIND YOU? SHE'S IN DEMAND FOR ACNE, PSORIASIS, AND ABDOMINAL SUPPORTS."

If You Need a Summer Substitute

*Things to think about when setting up
a locum tenens arrangement*



A patient rattling your locked office door may not stop to think that you probably need your vacation as much as he needs attention. So fragile an asset is good-will that many a physician has returned from a brief layoff to find he's lost part of his practice.

An obvious way around this is to ask a colleague to "hold you up" during your absence, in return for the same service from you. But today, when most physicians have all the patients they can handle, this reciprocal arrangement is not always feasible.

The alternative is to engage another doctor as a *locum tenens* to maintain your practice during your absence, then hand it back intact when you return.

How to find a *locum tenens*? Doctors who have done some searching recommend young hospital residents as likely candidates. If local staffs can't spare a man, they say, try other institutions in your state. Their directors usually cooperate.

The executive secretary of your medical society may be able to help. He knows which physicians

have just moved into the community; they are often in the market for *locum tenens* positions. Perhaps he can suggest the names of doctors in semi-retirement, or of those who work most of the year on a salaried basis, such as medical school faculty members. Men in those categories sometimes welcome the opportunity for part-time summer practice.

Another idea, especially practicable in large cities, is to insert a classified advertisement in local newspapers.

And don't overlook the possibility of getting in touch with a reliable medical exchange or employment agency.

Once you've found a man who can spell you, the next hurdle is the *locum tenens* contract. A short-term turnover can be handled as a gentlemen's agreement. But if you're taking an extended leave, bind the bargain with a written contract. Have a lawyer draw it up for you.

Whether you rely merely on a handshake or on a signed and sealed document, these basic points should be covered:

¶ Specify a time limit for the

arrangement and reserve your right to terminate it at any time.

¶ Fix responsibility for maintenance of your office and equipment; state explicitly who will bear the cost of upkeep during your absence.

¶ State precisely how your *locum tenens* will be paid, and how much.

Formal written contracts may also include non-competition clauses, arrangements for periodic accounting, a guarantee that your shingle will be maintained, and an allowance for death contingencies.

Most popular method of paying a *locum tenens* is on a fixed salary basis. This cuts down day-to-day bookkeeping and simplifies tax accounting.

But you have several other choices: A Detroit doctor with an especially competent secretary prefers to operate on a percentage basis. He pays all office expenses, allows his temporary assistant 50 per cent of the fees he takes in. A Denver physician lets his *locum tenens* keep 25 per cent of office fees, 60 per cent of house-call fees.

Your accounting set-up helps to determine the best method of payment. If your bookkeeper plans to take her vacation when you do, a strange physician would have trouble maintaining the records for a percentage system. Paying a straight salary or letting the *locum tenens* keep all the fees he collects is generally preferred.

Before you hand over your office key, let your substitute know just how much you expect him to do. Some doctors prefer an assistant who will merely keep the office open, answer the telephone, and handle emergencies. Others want their *locum tenens* to carry on just as they would.

Don't plunge your *locum tenens* into new surroundings without proper introductions. A printed notice is one way to tell your patients about the temporary change. Having your pinch-hitter in the office a week before you leave also helps. While you're introducing him around, don't overlook your colleagues.

—THOMAS BARR

S.R.O.

After I had entered the new patient's name in the appointment book, I asked him to be seated while awaiting his turn. To my surprise he refused, and started to pace the corridor. Finally I said, "Sir, if you'll have a chair, you'll be more comfortable and the doctor will see you just as soon." His answer was a snort: "Young lady, if I could sit down, I wouldn't have to see the doctor!"

—PHYSICIAN'S AIDE, OKLAHOMA

Survey of Miners Is Argument Against Federal Medicine

*Boone report shows effect of panel
system on private practice*



When Rear Admiral Joel T. Boone sent his five teams of Navy medical officers into the bituminous coal fields a year ago, no one doubted that they would turn up shocking facts about the caliber of medical care available to U.S. miners. They did. Few would have been surprised had they recommended a boondoggling system of compulsory health insurance. They did not.

Although the Boone report does not say so, it has produced new evidence of how compulsory health insurance would harm American medicine and the public with it. Coal miners do not receive medical care under a Government-sponsored compulsory program, but the parallel between such a system and contract practice is revealed in the findings of the Medical Survey of the Bituminous-Coal Industry.

The report carefully points out that medical care in some mining areas is good. But, in general, it says:

"The present practices of medicine in the coal fields . . . are synonymous with many abuses.

They are undesirable and, in numbers of instances, deplorable."

To cure the ills of mining medicine, Admiral Boone wants to:

¶ Abolish contract practice.

¶ Extend prepay plans similar to Blue Shield and Blue Cross.

¶ Raise the standards of medical ethics.

¶ Improve hospital, dispensary, and medical office facilities.

¶ Separate industrial medicine and general medicine even if the same physician practices both.

¶ Expand public health services by state and local governments.

The findings upon which the Boone recommendations are based point up the similarity between contract practice and panel practice under compulsory health insurance. The surveyors found many miners compelled to participate in the contract system. Under it, patients have no choice or limited choice of physician. While physicians compete to win contracts, once they have been signed up their incomes are assured; no element of competition spurs them on.

[PLEASE TURN TO PAGE 46]

At the same time, the investigators report a tendency among miners to be too "doctor conscious" and to overwork their contract rights. Frequent interference from laymen—both operators and union officials—is also revealed.

How lack of competition affects medical practice is described thus: "A few of the physicians maintaining unattractive and disorderly offices in company camps conducted private offices in near-by towns, to handle non-contract cases. These offices, where patients were seen on a fee-for-service basis in normal competition with other physicians, invariably were tidy, well-kept, and adequately equipped."

What happens when laymen control the assignment of patients to physicians is shown this way: "Both management and labor appear in a few instances to have abused their responsibilities and privileges. This is evidenced by the fact that the physicians were not selected primarily on the basis of professional qualifications and the character of the facilities and services that were offered but on the basis of personal friendships, financial tie-ups, social viewpoints, or other non-medical considerations."

How medical ethics deteriorate when laymen can consign patients to doctors is clearly indicated: "In one case a druggist with no medical training was practicing medicine in an isolated Kentucky community, receiving his share of the payroll check-off along with two

regularly qualified physicians. The latter were compelled by the local union to accept this condition so long as the pseudophysician 'does the right thing.'"

Several minor forms of graft in this panel system are described: "A few physicians admitted that an understanding existed between themselves and the operators, that, in exchange for receiving check-off funds, they would not charge the company for performing pre-employment physical examinations or rendering certain other industrial services, such as treatment of minor industrial injuries . . . Certain of these physicians expressed resentment . . . On the other hand, two physicians volunteered that they offered the mining company this inducement in order to obtain appointment over their competitors."

Although the survey clearly shows a bad spot in American medicine, the operators, the union, the local governments, and, to some extent, the miners themselves get the greater share of the blame for conditions in mining towns.

Some state governments, for example, have failed to extend health programs to school and pre-school children. Others have no workmen's compensation laws. A few are not making full use of the Federal Hospital Survey and Construction Act.

Some mine operators, on the other hand, allow company-owned homes to run down and do not provide potable water in mining

camp. Others have overlooked their responsibilities in industrial medicine and industrial hygiene.

While in only a few cases is the United Mine Workers expected to provide services, the Boone report suggests that the union pay more attention to public health, sanitary, and housing conditions; that it give more help to communities needing local hospitals; and that it try to fix the true costs of adequate medical care for miners.

Among the miners themselves the survey teams found a general lack of initiative and an unwillingness to assume the responsibilities of mature citizens.

What labor, management, and government can do is plain, says the report. But until the operators and union bosses do their part, medicine can only (a) insist that the rules of medical ethics be followed; (b) offer to help operators and union officials set up sound industrial medical practices; (c) and offer to advise them on the establishment of a broader prepay system.

Admiral Boone's recommendations on prepayment pose some unfamiliar problems. To supplant the contract system, he asks for the extension of medical care plans of the Blue Shield and Blue Cross type. But he also says that certain special features should be included. For example: "Frequent periods of unemployment make it essential that provision be made in all plans to extend credit to subscribers

when they are not gainfully employed and to permit participants to receive benefits after employment is terminated."

Other special features Admiral Boone asks are:

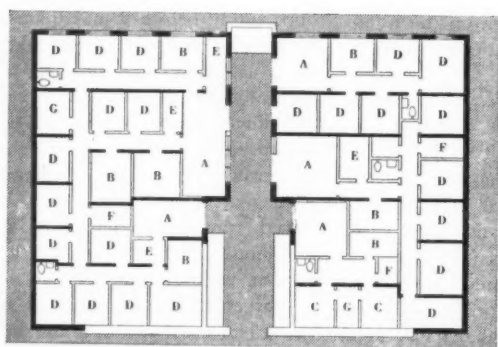
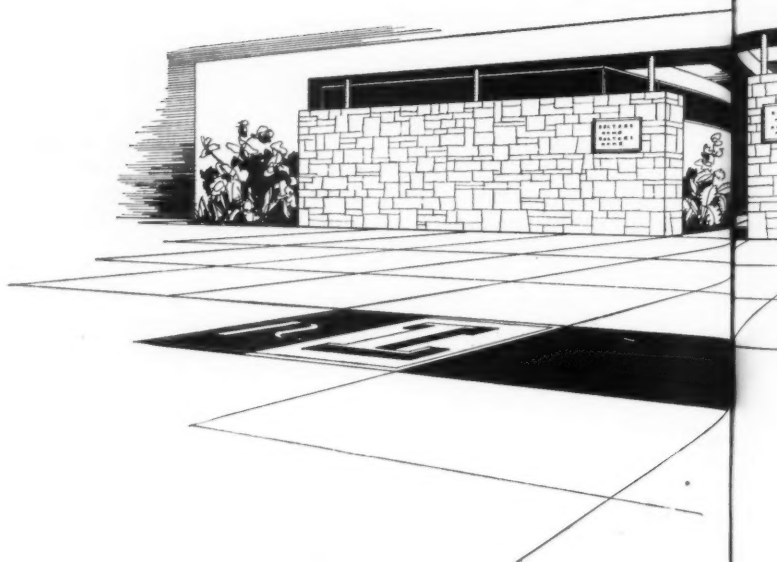
¶ Provisions for transporting patients to hospitals in places where hospitals are not readily available.

¶ Diagnostic clinics to combat the high percentage of closed-staff hospitals in mining areas.

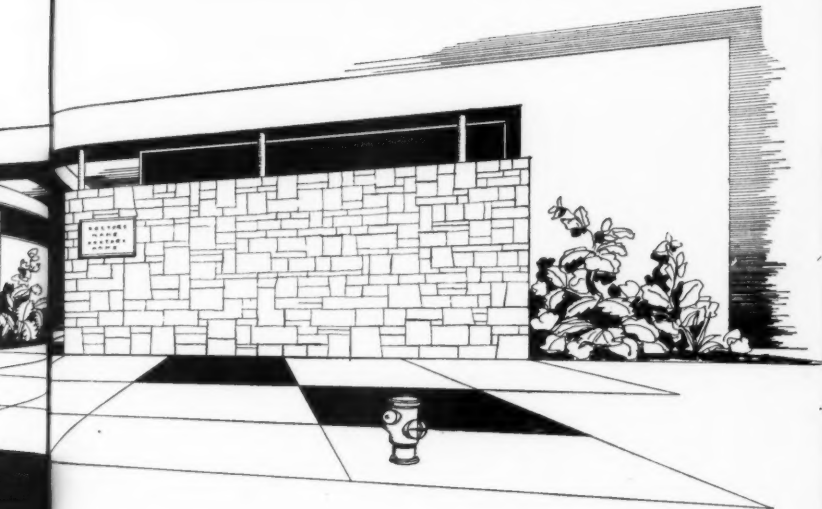
¶ Programs to advance preventive medicine and health education.

Admiral Boone does not say that organized medicine should establish a prepay plan to include these benefits. He indicates that it may be a job for the United Mine Workers or for the operators. But a door is left open for medicine. The Boone report views medicine's position this way:

"The medical profession faces an opportunity of challenging proportions. Its responsiveness is dependent upon its perception of the opportunity before it and upon its sense of responsibility in taking every action to make medical service and its benefits available to each individual. There is evidence that organized medicine is desirous of measuring up to the challenge. Management and labor, it is believed, can find an interested and ambitious ally in the medical profession, willingly ready to work as a partner in the enterprise of improved medical facilities and high health standards in the coal industry." —EDMUND R. BECKWITH, JR.



Arrangement of room
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Examination, (E) Bus
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Office-on-a-Patio for Seven M.D.'s

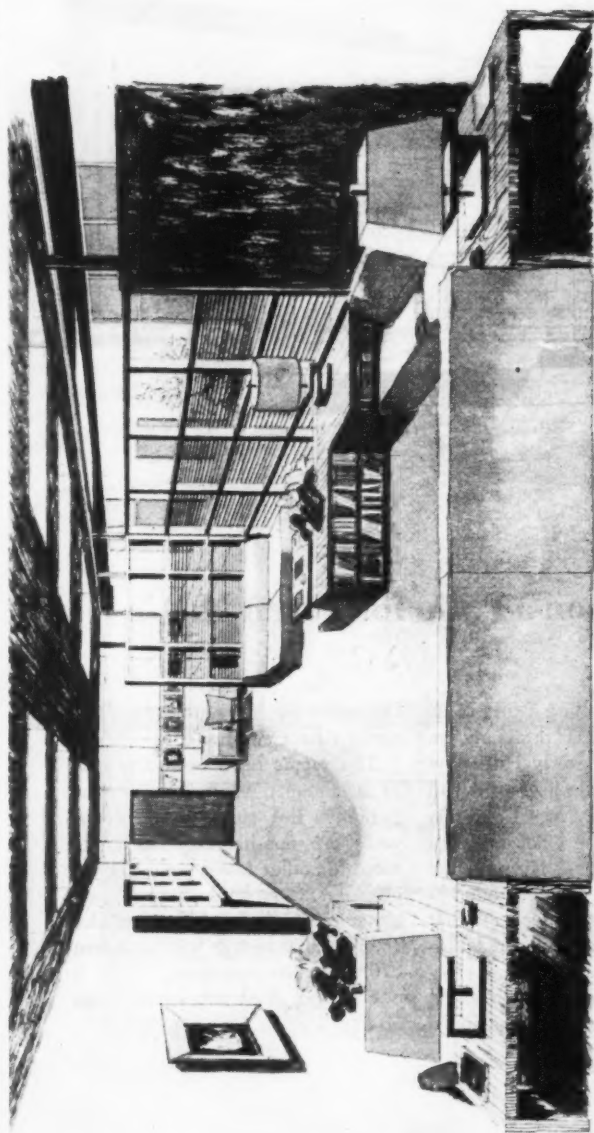
When Hungarian-born Paul Laszlo took on the job of designing an office for seven Beverly Hills physicians, his problem was to blend the sprawling grace of a California bungalow with the efficiency of a professional building. He solved it by grouping the suites around a sheltered patio (see cover) that runs dead-center through the building's entire depth.

Architect Laszlo says that the construction materials used make

this office adaptable to brisker climates than California's.

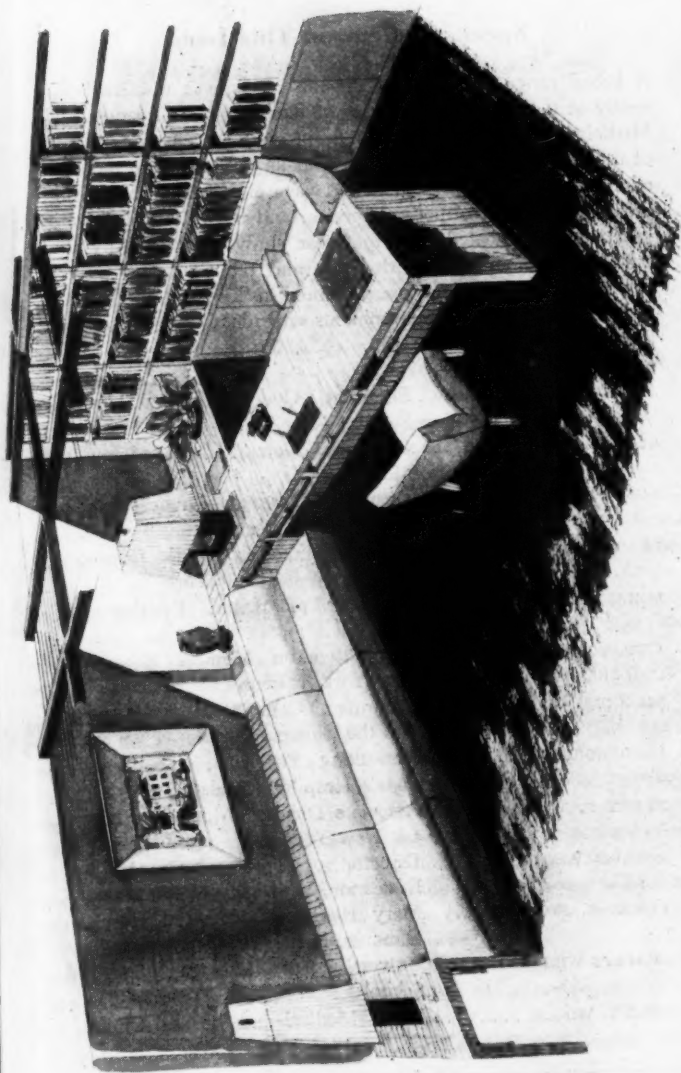
The rooms have been arranged to suit the men who will occupy the building. But since most interior walls are non-bearing, rearrangement for other tastes would be no problem. Completely sound- and air-conditioned, this office contains 75,660 cubic feet. It will have cost \$70,000 when completed.

For other illustrations, see pages 50 and 51.



Narrow reception room (above), shared by three doctors, derives its illusion of width from solid glass wall. Low, leather couches break up its length into semi-private sections. Potted plants bring fresh patio atmosphere indoors. Sample consultation room (below) is windowless, but glass ceiling allows natural light. Drawers under bookshelves eliminate need for filing cabinets.

(below) is windowless, but glass ceiling allows natural light. Drawers under bookshelves eliminate need for filing cabinets.



Special Articles in This Issue

A broad range of medical-economic issues was discussed recently at the centenary program of the New York Academy of Medicine. Among the most significant were the changing status of the general practitioner; how to make post-graduate medical education more readily available; ways and means of offering more comprehensive medical service; and the future of private practice, as indicated in a four-year study completed by the academy's Committee on Medicine and the Changing Order. Reports of the discussions are presented in this issue of MEDICAL ECONOMICS. Included are comments and ideas from these participating physicians:

| | |
|--------------------------|--|
| ALFRED ANGRIST..... | President, Queens County Medical Society, New York |
| GEORGE BAEHR..... | President, New York Academy of Medicine |
| ROBIN BUERKI..... | Dean, Post-graduate Medical School, University of Pennsylvania |
| DEAN A. CLARK..... | Medical Director, Health Insurance Plan of Greater New York |
| DONALD M. CLARK..... | General Practitioner, Peterborough, N.H. |
| CARL EGGERS..... | Committee on Medical Education, New York Academy of Medicine |
| MALCOLM GOODRIDGE.... | Chairman, Committee on Medicine and the Changing Order |
| LORD HORDER..... | Consulting Physician, St. Bartholomew's Hospital, London |
| HENRY B. MAKOVER..... | Associate Director, Montefiore Hospital, New York |
| WILLIAM A. O'BRIEN..... | Director of Post-graduate Medical Education, University of Minnesota |
| LESLIE K. SYCAMORE.... | Mary Hitchcock Memorial Hospital, Hanover, N.H. |
| CHARLES WILKINSON JR.... | University of Michigan Medical School |
| OZRO T. WOODS..... | Dallas Medical and Surgical Clinic |

'Revise the Role of the G.P.— Or Get Rid of Him!'

*Changed future predicted
for family doctors*



Is the family doctor all washed up? Dr. Donald M. Clark, who has been one for twenty years, thinks so. More than that, he thinks it's just as well.

"My only assistants," he says, "are a nurse, a technician, and a secretary. Yet in 1945 we had to handle 12,000 home and office calls of all types. This sort of thing should have stopped twenty-five years ago. It is one of the most dangerous types of practice in this country."

For every two G.P.'s, he declares, there should be, instead, an internist and a surgeon.

G.P.'s who heard Doctor Clark write off the family doctor at a recent meeting* were quick to disagree. Many offered their own ideas for reclaiming the G.P. from the limbo of "forgotten men." But few denied the frustrations that face today's family physician. Dr. Alfred Angrist describes him thus:

"The G.P. is a doctor who was unable to obtain a residency and get specialty training, or who could not afford to. He accepted general practice, as a compromise, not as

an opportunity for service. He finds it difficult to get a hospital appointment. Even if he succeeds, the chances for professional stimulation and research are denied him. That reduces him to a static state, and that means mediocrity."

Doctor Angrist continues: "The present one-year service of an interne gives the G.P. very little training; and still we expect him to practice good medicine. Once the vicious cycle of accepted incompetence, inadequacy, and disappointment is introduced into the G.P.'s role, it is difficult to expect a miracle.

"Our general practitioners are twenty years behind the times. That is almost an expected outcome of this policy. What is more important, it breeds a peculiar dissatisfaction with the status quo. Such men look on the specialty board as a monopolistic control of the better type of medicine."

What does all this unrest lead to? For one thing, to demands (such as Doctor Clark's) that the G.P. be eliminated. Doctor Angrist takes issue with this view. "If we do that,"

*See introductory box, page 52, this issue.

he says, "we are just adding another six or seven years to medical education. Until we can extend medical care to places that need it most, I think we should hesitate to shorten the actual practicing period of the M.D."

Another result of the G.P.'s frustration: Fewer medical students want to become family doctors. Dr. Charles Wilkinson Jr. remarks wryly: "I interviewed most of the senior medical students in our last class at Michigan. I found that nineteen were going to be brain surgeons. About twenty were going into ENT. Twenty-five or thirty were going into internal medicine, and several were planning to be gynecologists, allergists, and what-not. I'm afraid we didn't graduate anyone who was going to take care of sick people."

Dr. William A. O'Brien adds: "Medical educators have been accused of this drift toward specialism. But we checked our graduating seniors and discovered that 90 per cent planned to be specialists. Then we checked our entering freshmen; the figure was 90 per cent there, too."

Other men refuse to absolve the educator. Says Dr. Carl Eggers: "Very little is heard of training doctors for general practice. If you query an educator on this subject, you're met with a shrug. What does this mean? Are we ready to discard the general practitioner? Or has he actually been forgotten?"

The way out of the woods, Doc-

tor Angrist thinks, lies in revitalizing the G.P.'s training. "We have lost sight of the major contribution the general practitioner can make," he says. "I wish not only to defend the G.P. but to ask for his emancipation and resurrection to his former place of importance in dispensing medical care."

"What it adds up to is a reorientation of medical education, and a revolutionary one. It will bring into the medical schools, to a much greater degree than now, social and preventive medicine and medical economics. In this we need the cooperation of medical schools and hospitals."

The doctors quoted agree on one thing: that there should be a change in the emphasis of internship. Doctor Eggers points out that "pre-war internships served admirably as preparation for general practice. But during the war few men had an opportunity to serve internships longer than nine months. It was generally felt that this short training period was inadequate. Yet there is a tendency at present to accept the one-year internship."

"This does not fit our lofty ideas of medical progress. Provision has been made for the training of specialists over periods of five years. Yet no provision has been made for the adequate training of the general practitioner. Nevertheless, the educational level at which the G.P. starts determines to a great degree the public's respect for the medical profession as a whole."

Not only should internships be longer, says Doctor Eggers, but more of them should be transferred to rural hospitals. "Suburban and rural hospitals could share in the training of family doctors much more than they do now," he explains. "The hospitals of large cities, especially those of medical centers, must train men not only for local needs but for the country as a whole. But smaller and less important hospitals also have to be utilized. Perhaps many of the non-teaching hospitals could be brought within the orbit of medical schools to train internes on a higher level than at present."

Dr. George Baehr suggests a third change in education slanted for the G.P.: Get practical teachers! "In our medical schools," he says, "the professors are quite properly full-time experts. But very few of them have ever practiced medicine. They haven't any idea of the problems of the general practitioner. One is astonished, on coming in contact with them, what a poverty of information exists there. The teaching of medicine must be in the hands of men who have some understanding of the problems of sick people. Only a reorganization of our schools' medical departments can achieve this."

Those, then, are suggested ways of bettering the G.P.'s training. How can such ideas be fitted together into a practical plan?

As an example, Doctor Wilkinson proposes a G.P. training pro-

gram that is under consideration at the University of Michigan Medical School. In that state many good hospitals of 120 to 150 beds, staffed mostly by G.P.'s have no interne programs. "Our plan," he says, "is to set up a two-year training program for the man who has just come out of medical school. He would go to one of these hospitals as an interne. But during this period he would also get six months at the university. There he would continue his courses. He would get ward work in medicine, pediatrics, obstetrics, psychology, and surgery."

Such a plan, he believes, would help resuscitate the family doctor—"and there's no blinking the fact that the G.P. needs resuscitation." At a recent grange meeting, Doctor Wilkinson recounts, "one member rose to say that all this talk about new hospitals was fine, but his community had no doctor. No physician had ever come to replace the practitioner who had died six years before. Incidents like that—they've happened all over Michigan—show why our whole attitude has to change."

Once you've produced a well-trained family doctor, how can you encourage him to keep up to date? Dr. Robin Buerki tackles this problem, saying, "I question whether you can take a license from a physician because he hasn't kept up. But you *can* have a 'specialty' board for family doctors to certify that a man has kept up.

[PLEASE TURN TO PAGE 79]

Bickering Over Health Bills Continues

*Organized medicine finds few supporters
at Senate committee hearings*



A number of Federal health bills languished last month in committee. There seemed little likelihood that any would be passed at the present session of Congress.

The Senate Committee on Expenditures in Executive Departments, headed by Sen. George D. Aiken (R., Vt.), had completed hearings on two bills proposing a Federal Department of Health, Education, and Security. The National Health Bill (S.545) of Senators Taft, Ball, Smith, and Donnell had been referred to the Health Subcommittee of the Senate Labor and Public Welfare Committee, headed by Sen. H. Alexander Smith (R., N.J.). Hearings on S.545 were to begin May 21 and were to last several weeks. The Health Subcommittee planned to have a full statement of arguments in favor of voluntary medical insurance.

Meanwhile, a new Wagner-Murray-Dingell Bill had been drawn up and was being privately circulated. Eleanor Roosevelt was plumping for it in her syndicated newspaper column; but it appeared doubtful that there would be any hearings on it. The consensus of the Health Sub-

committee seemed to be that arguments for Federal medicine had been completely aired last year. There had been thirty-one hearings on S.1606; more than 250 witnesses had been heard.

The Labor and Public Welfare Committee, which would consider the T-B-S-D Bill was closely drawn. Two of its Republican members, Senators Aiken and Wayne Morse (R., Ore.), appeared likely to join the Democrats in promoting legislation opposed by organized medicine. Both men were cool toward organized medicine; both had reproved it for alleged propaganda efforts.

The two measures Senator Aiken's committee had considered were:

The Fulbright-Taft Bill, S.140, to establish a Department of Health, Education, and Security, headed by a Secretary of Cabinet rank. Of three Under Secretaries specified in this bill, one would be an Under Secretary of Health and a licensed doctor of medicine.

The Aiken Bill, S.712, to transform the Federal Security Agency into a Department of Health, Education, and Security. This bill also provided for a Secretary with Cabi-

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net status, plus an Under Secretary and two Assistant Secretaries, one of whom would presumably be in charge of health.

In many respects, the hearings on S.140 and S.712 had been a curtain-raiser for the impending struggle over the Taft-Ball-Smith-Donnell Bill and the new Wagner-Murray measure. But in the course of the hearings medicine had found few friends. In all, three broad viewpoints had emerged:

1. Liberal groups unanimously upheld Senator Aiken's proposal to give the Federal Security Agency control of Government activity in the fields of health, education, and security.

2. Organized medicine wanted action deferred until the whole subject of health could be explored at later hearings. It also favored a separate Cabinet seat for a Secretary of Health.

3. Senator Taft thought that a tripartite department would work if health activities were directed by an Under Secretary with professional qualifications. He believed further that medicine's efficiency would not be inhibited under such a department.

Finding himself pretty much alone, the Senator from Ohio could only hope that executive expenditures committee would deadlock and refuse to report either bill before it. Meanwhile, the Senator from Vermont was pressing hard for adoption of S.712 with only minor amendments.

In the process, Mr. Aiken seemed to scent a conspiracy on the part of organized medicine. To a number of physicians who had urged delay he wrote a tart reply:

"I am sorry I do not share your feeling that S.140 and S.712 should be held up pending action by another committee to which S.545 was referred. It is fairly certain that Congress will not see fit to create two or three new Cabinet posts, so that if the health program is to be headed up by an officer having Cabinet rank or its equivalent, which seems eminently desirable, it will have to be through its inclusion in a department having a wider field of operations. The desirable features of S.545, including the coordination of Federal health activities, can be incorporated in either of the other bills or acted upon at a later date whether or not a Department of Health, Education, and Security is created.

"I do not believe you are advancing the cause of health or the reputation of the medical profession by the dog-in-the-manger at-

Handittp

Magazine Racks

Several small magazine racks, each within easy reach of a chair or sofa, are often more convenient for waiting patients than a single table that holds all your reception room reading matter.

titude of advocating delay in consideration of S.140 and S.712. Since extensive hearings, at which representatives of medical organizations testified at considerable length, have been held on the two bills, the purpose of the maneuver is rather apparent. I strongly disapprove of the propaganda campaign which is being conducted, apparently under the sponsorship of one or more national organizations."

Senator Morse also made his position clear: "If the medical profession thinks for a moment that the American people are going to turn over to it the job of determining public policy in protecting the health of the people, it is sadly mistaken. The doctors had better read

the handwriting on the wall . . ."

Watson Miller, Federal Security Administrator, said that should the FSA be elevated to Cabinet status, he would not want a professional Under Secretary. "Officials appointed to represent their respective professions," he said, "are not likely to be the most helpful to the Secretary in the all-important task of giving common direction to the several professional groups and points of view within the new Department."

What's more, Mr. Miller added, he could get more done by himself than with three Under Secretaries. Such officials, he feels, "would unduly emphasize the professional work of the new Department at the



"PARDON ME, ARE YOU PREGNANT?"

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expense of its broad public services; would impede selection by the President of the best qualified administrators; and would make distinctly more difficult the processes of coordination among the different but related functions of the Department."

At the hearings, Drs. R. L. Senenich and James R. Miller, representing medicine, testified that the AMA had been suggesting, since 1894, an executive Department of Health, headed by a qualified doctor of medicine. They argued that the grouping of Federal health activities under such a man, as proposed in the Taft National Health Bill, would provide an opportunity to test such an arrangement. Action on a Cabinet department, they said, should be deferred.

Other viewpoints:

Joseph H. Louchheim, Committee for the Nation's Health: Enact the Aiken Bill. Prohibit professional requirements for administrators because they "run counter to American principles of government." Stymie the efforts of the AMA "to obtain control over the administration of the health functions of the Government."

Lawrence L. Gourley, American Osteopathic Association: The Taft (Cabinet) Bill is bad because it stipulates that the Under Secretary for Health be a doctor of medicine.

Stanley Ruttenberg, CIO: The Taft bill would open the door for private agencies "whose activities

are judged to be anti-social and inimical to the best interests of American wage-earners."

Robert A. Fischelis, American Pharmaceutical Association: No objection to a Department if the functions of the Food and Drug Administration and Public Health Service are not impaired.

J. Ben Robinson, American Dental Association: Neither S.140 nor S.712 "is in the best interests of the health and welfare of the people."

George F. Zook, American Council on Education: Enact S.140, but recast the name of the department so Education would appear before Health and Security.

MEDICAL ECONOMICS asked Senator Aiken to define the "dog-in-the-manger" attitude he had imputed to doctors. He replied:

"Every medical association has been given full opportunity to testify. Every citizen has a right to express his conviction on these bills. But I believe that if Cabinet status and a voice in the policy-making of the Executive Department is to be given to health, education, and welfare, it must come through a department embracing all three. No advantage can be gained by side-tracking education and welfare in favor of a bill benefiting medicine alone. I believe such a procedure unwise . . . I cannot agree to giving one group procedural advantage over others and do not believe that the medical profession as a whole would want me to."

—E. K. BUCHANAN



FIREHORSE



Last New Year's Eve, Harry M. Archer, 78-year-old honorary chief surgeon of the New York City Fire Department, was preparing to "step out." Before he could do so, the special fire alarm in his apartment began to clang furiously. Party forgotten, the doctor, in dinner clothes, was soon wading waist-



deep through water to reach an injured fireman in the basement of a flaming building. Before the evening was over he had also climbed an ice-coated, thirty-foot ladder into a smoke-filled loft to aid two other firemen and crawled through a tunnel of debris to administer morphine to four more.

Doctor Archer regards his rescue work as commonplace. Nevertheless, it has made him known as the "guardian angel" of New York fire-

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men. No one knows how many firemen he has helped to rescue, but he has received two fire department medals for heroism and the James Gordon Bennett medal for bravery. The fire department has also created the Archer Medal, awarded to firemen for meritorious service.

Doctor Archer has never been in the fire department's employ; but an interest in fires and an awesome loyalty to the men who fight them have made him the department's honorary chief surgeon. There was a movement some years back to have him appointed Fire Commissioner of New York, but he discouraged it. He wanted the post to go to someone from the ranks.

After his graduation from Bellevue, he stayed on for six years as assistant professor of surgery. Then he took a position as examiner for the Aetna Life Insurance Company. He became its chief surgeon in 1914 and is now its medical director.

But he has never let anything interfere with his fire-chasing. Once, while vacationing in California, he learned that several members of his favorite Company 56 had been hurt in a fire. He took the next plane east.

He has narrowly escaped injury many times during fires. On one occasion falling debris broke an arm and two fingers.

Doctor Archer was born in a building next to a firehouse in Manhattan. At 10 he organized his friends into a "fire company," with

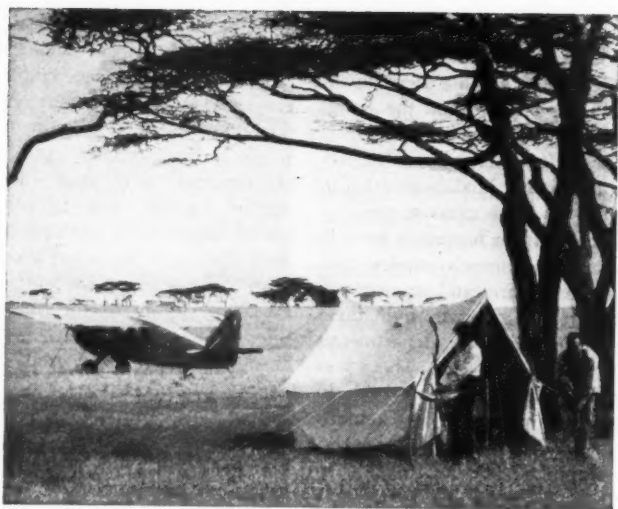
headquarters in the Archer stable. Members of this clan would hang around the firehouse listening to the firemen's stories. Any youngster frequenting the same firehouse today would be likely to hear a good deal of reverent talk about Doctor Archer himself, but the doctor would undoubtedly pooh-pooh any such idolatry if he heard about it. "I just sort of supervise things," he says. "Any other doctor would do the same."



GLOBEMASTER



When Lindbergh turned the Gay Twenties goggle-eyed with his historic flight, at least one person stayed that way. No sooner had Richard U. Light pulled down his M.D. than he pulled on the goggles of an Army aviation cadet. Lindy's hop had sold him on an aerial ad-



Just what the doctor ordered: The Lights pitch camp (above) on Africa's Serengeti Plains to top off their aerial menu with zebra steak (below).



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venturer's life. It took some high-grade hustling, but Doctor Light won his wings at Kelly Field just before his hospital assignment came due.

Older physicians at Boston's Brigham Hospital recall being mildly stunned when their newest interne showed up in his own plane. Doctor Light's wanderlust didn't interfere with his medical career; he went on to teach surgery at Yale and Rochester. But even as an interne, he showed an un-Bostonian interest in faraway places.

Whenever he could find a gap in his schedule, he would take off for Mexico, or perhaps Panama. In 1934 he flew three-quarters of the way around the world. Since the trans-Pacific odds at that time favored a diet of rubber rafts and seagull stew, Doctor Light covered the final quarter by boat.

Jaunts like these whetted his enthusiasm for first-person geography. Typically, he spent two years preparing for a climactic African flight. He put his wife through a stiff course in radio code until she won her commercial license. He showered her with flying lessons until she could spell him at the controls of his Bellanca Skyrocket. He hobnobbed with geographers all over the country. Then came the pay-off: a 20,000-mile tour of the Dark Continent.

Aerial panoramas the Lights brought home were published in "Focus on Africa," 1941. They won accolades from geographers every-

where. Along with the panoramas were a number of striking close-ups: one showing three lionesses lunching on a baboon. Once during the trip, Doctor Light recalls waving a flashlight sleepily in the faces of four "hyenas" that were nuzzling against his tent. Turned out to be no laughing matter—they were full-grown lions.

In Tanganyika, the doctor's flight operations were thrown askew by a native quirk. Airport wind socks disappeared as fast as they were put up; local citizens had discovered they made excellent trousers. Only when wind socks made of old convict suits were hoisted aloft could Doctor Light use the field without risking his neck.

The two-month trip ended abruptly on Corsica when a 100-mile wind blew the Lights' plane out of its hangar. Picking up the pieces, the doctor packed them aboard a small steamer. Once again he came home by boat.

Today he runs a busy neurosurgical practice in Kalamazoo, where he was born. Early this year he was elected president of the American Geographical Society, the first non-New Yorker to hold that post since Admiral Peary. He's working now on an "atlas of diseases" that spans the gap between his vocation and avocation. Says one noted geographer: "It shows what a far-reaching contribution modern geography can make to medicine."

As for Doctor Light's own career, one might add, "and vice versa."



BENCHWARMER



You could have knocked Robert F. Hyland over with a bean ball when his parents packed him off to medi-

cal school. He had been all set to cavort around first base for Grand Rapids in the old Central League, his sights set on the majors. But instead of swinging a Louisville slugger, he soon found himself wielding a scalpel and swab.

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Even outside Flatbush, baseball enthusiasts are a hardy lot. So it's not surprising that Doctor Hyland found another way to crash the big leagues. Today bleacher fans in every park know him as "Doctor Baseball." During the last thirty years, he has won his spikes by patching hundreds of ailing diamond stars.

From 8 to 3 every day, the tall St. Louis surgeon scoops up everything a local traction company bats his way. He has run an industrial practice ever since he got his M.D. Comes midafternoon, though, and he's off for the ball park. Settled comfortably in the grandstand, armed with peanuts and soda pop, he may look like any ordinary fan. But the men on the diamond know better.

"I'll wait till we get to St. Louis" is a familiar reaction from lame-arm fireballers and weak-back sluggers. It's Doctor Hyland they're waiting for. His specialty is baseball injuries. Ten per cent of all pitchers, he estimates, have elbow trouble that calls for medical guidance. More often than not, he's the one to supply it. He completed a neat double play on the Dean family: put the zip back in Dizzy's fast ball ("interesting rupture of the supraspinatus tendon," he recalls) and did the same for Brother Paul.

His surgery converted John Mize from a swatter who couldn't stoop for the low ones to a prodigious fence-buster. He has helped stars like Pete Reiser, Mort Cooper, and Pepper Martin nip ailments that

were giving them a dugout tan. His diamond devotion extends to big-leaguers' families, even to itinerant baseball writers, whom he mends at the drop of a bat.

Last month, the Cardinals, languishing in the National League cellar, were numbed by the possible loss of first-baseman Stan Musial. The star hitter came down with an acute appendicitis. Sports writers predicted an end to the team's chances to win the pennant if Musial were out for six weeks. But the slugger was flown from New York to St. Louis for Doctor Hyland to examine. If he could keep the ballplayer in the lineup till season's end, the Cards might very well hoist the championship pennant over the Hyland ridgepole. There might be some grumbling among the other teams about the Cards having fielded ten men.

Doctor Hyland makes light of his contribution to the American game. "Just a hobby of mine," he says. "I love baseball, and I find that the sport presents unusual injuries not seen in regular practice."

He broke into the big leagues via two St. Louis club-owners, for whom he served as personal surgeon. Until a traffic accident some years ago, he worked out regularly with the Browns.

He has never billed anyone for his diamond surgery. But whenever one of his ex-cripples fogs a third strike across the plate or hammers a lusty blow against the scoreboard, he beams as if he'd done it himself.

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Fee Crisis Faces Home-Town Plan

*V.A. asks state societies to readjust
fee schedule to national ceiling*



Is the honeymoon over? It seemed so last month. Relations between the Veterans Administration and a number of state societies were badly strained because of the "home-town" plan of private medical care for veterans. The V.A. had told the societies, in effect: "We've got to renegotiate your contracts. And this time it's going to mean sharpening your pencils." A number of medical societies showed plainly that they didn't like it.

The V.A. made its move reluctantly. It was aware of the storm of protest it might evoke. But already the new Congress was weighing a half-million-dollar budgetary cut for the agency.

There had been murmurs that the V.A. wasn't watching its dollars closely enough. So the V.A. was fine-combing its operations for signs of carelessness or extravagance. Meanwhile, it sent word to its regional directors that authorization of private treatment would have to be reduced until Congress made up its mind how much V.A. money it was going to appropriate.

To prove it meant business in tightening the home-town program,

the V.A. distributed a new, standard bid form, containing "ceiling" fees. Medicine surmised that it was getting a national schedule, that the administration planned to establish uniform fees throughout the states. The V.A. said no. Dr. Paul R. Hawley, chief medical director, summed up its position:

"We don't intend to establish a uniform fee schedule for all the states. But there are complaints that we have accepted fees which are higher—for the region or community—than those charged private patients. We have also been accused of increasing private fees by accepting certain state-wide schedules. The fact is, our home-town plan is being subjected to strict scrutiny. The administration from now on must be able to justify the acceptance of every state contract."

Dr. J. C. Harding, assistant medical director, added: "The ceiling is not rigid. If any society can demonstrate that its members are entitled to a fee higher than the one we list, we will be inclined to go along with it."

In preparing its "Fee Schedule for Medical Services," the V.A.

tried to accomplish two things:

1. *Place a ceiling on fees.* "There is a wide discrepancy among comparable fees in the thirty-eight contracts now in effect," V.A. spokesmen said, "and they do not necessarily follow regional differences in living costs, business expenses, or population densities. It is difficult, if not impossible, to explain to a critic why we should pay \$150 for a procedure in one state and only \$100 in a neighboring state of similar economic status."

2. *Establish a uniform, complete format.* Coordination of the thirty-eight current contracts, for statistical or actuarial purposes, was impossible, said the V.A., for no two were alike. Terminology often was vague and incomplete, it added, and important procedures frequently went unlisted.

One doctor retorted: "No matter how you explain it, it's still a national fee schedule. When contracts are renegotiated, you may induce some states to lower their fees down to the ceiling. But how are you going to prevent other states from raising theirs?"

Until all societies had submitted new bids, the V.A. could not answer that. But every organization, government or private, with an established fee schedule was watching to see what would happen.

The Veterans Administration knew that no one had yet been able to draft a medical fee schedule that pleased everyone. Its job was the more difficult because it had no place

to start from. Its old national fee schedule was obsolete; it had never been satisfactory to doctors anyway. Workmen's compensation fees would serve as no criterion, for they were under attack generally. Schedules of prepay plans varied. So did those of the thirty-eight current V.A. contracts.

The administration asked the AMA for help but was turned down. The association wanted no part of such a thankless task. Finally, it called on its clinic directors and consultants, including some outstanding private specialists. They went to work. The new fee schedule is the result.

What does it mean to the doctor on Main Street? The answer is to be found in Part I (see accompanying table). This section, says the V.A., covers more than 75 per cent of the private fees authorized by the administration, and consists mainly of outpatient services in the physician's office, veteran's home, or hospital. Part II covers specialist treatment in the hospital, which is now but a minor factor in the hometown plans and is likely to become even less important as the V.A. gets more of its own hospitals into operation.

In an economic sense. Part I is the essence of the new schedule as far as the general practitioner is concerned. If his society exercises its option to accept Part I now and to debate Part II later, he may feel that any quarrel over specialists'

[PLEASE TURN TO PAGE 68]

fees is of only academic interest to him.

Few physicians who have dealt with Doctor Hawley's agency doubt its sincerity in attempting to iron out fee inequalities. "But," they ask, "why didn't the administration do this eighteen months ago when the home-town plans were getting started? Why get us all enthusiastic

about the V.A., its program, and its understanding of our problems, and then let us down with a thump? Wouldn't it have been better, a year and a half ago, to say frankly: 'We've erected a national ceiling on fees and it's up to you to stay below that ceiling or to show us why you can't?'"

The V.A. replies, in effect: "We

VETERANS ADMINISTRATION FEE SCHEDULE FOR MEDICAL SERVICES

PART I

(If two or more medical services are performed on the same patient concurrently by the same physician, the fee for the two or more concurrent procedures will be the greater or greatest fee plus one-half each smaller fee or fees.)

VISITS AND EXAMINATIONS

| | Visits within city limits | |
|--|---------------------------|------------|
| | First | Subsequent |
| Day: 8 A.M.—7 P.M. | | |
| Office | \$3.50 | \$2.50 |
| Home | 4.00 | 4.00 |
| Hospital | 4.00 | 3.50 |
| Night: 7 P.M.—8 A.M. | | |
| Home | 7.00 | 7.00 |
| Hospital | 7.00 | 7.00 |
| Charge for mileage one way for day or night visit outside city limits in addition to appropriate fee | | .75 |

SPECIALISTS' EXAMINATIONS

| | |
|--|---------|
| General surgical | \$ 7.50 |
| Orthopedic | 7.50 |
| Heart, complete, including electrocardiogram | 15.00 |
| Electrocardiogram, with interpretation | 10.00 |
| Lungs, physical | 5.00 |
| Chest, roentgenological | 10.00 |
| Gastrointestinal, including barium meal and enema, X-ray and fluoroscopy, with preliminary KUB film | 35.00 |
| Dermatological | 7.50 |
| Allergy investigation, including history, physical examination, relevant laboratory procedures (skin tests, smears of sputum and nasal secretions, vital capacity, etc.), and report | 30.00 |
| Allergy, diagnostic skin tests only, intradermal or scratch, 40 extracts | 15.00 |
| Each additional intradermal or scratch test | .25 |
| G.U., without cystoscopy, including prostatic smear and urinalysis | 10.00 |

were so busy then in taking over a rundown organization and rehabilitating it, and in attempting to get thousands of private doctors on the job quickly, that we took every short-cut possible. One of the short-cuts was acceptance of disparate fee schedules.

A few societies, the V.A. reports, have indicated willingness to re-

negotiate. But others are prepared to resist.

Up to last month, there were no indications that veterans' organizations were aware of what was going on. But it was inevitable that the news would leak out. It was certain that if veterans decided they had been caught in the middle, an uproar would result. —E. K. BUCHANAN

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| G.U., with cystoscopy | 25.00 |
| Gynecological | 7.50 |
| Proctological, rectal speculum | 5.00 |
| Psychiatric: 1 hour (50-60 minutes) | 10.00 |
| Each half-hour (25-30 minutes) additional to original hour | 5.00 |
| Neurological: 1 hour (50-60 minutes) | 10.00 |
| Each half-hour (25-30 minutes) additional to original hour | 5.00 |
| Ears, nose, and throat | 5.00 |
| Ear, special, including caloric or Barany test with audiogram and report | 20.00 |
| Ear, special, including audometric test with chart | 10.00 |
| Eyes, with refraction, manifest or cycloplegic, to include either a copy of the prescription or a report of the refractive error and fundus findings, as well as a report of abnormalities | 10.00 |
| Eyes: the above plus a report of the visual field findings (by chart if the field is abnormal) | 12.50 |
| Internist's examination to determine diagnosis | 15.00 |

SPECIALISTS' EXAMINATIONS, OUTPATIENT

| | |
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| Dermatological: first visit | 5.00 |
| Each subsequent visit | 3.00 |
| Ear, nose, and throat: first visit | 5.00 |
| Each subsequent visit | 3.00 |
| Ophthalmological: first visit | 5.00 |
| Each subsequent visit | 3.00 |
| Psychiatric (psychotherapeutic conference): | |
| One hour (50-60 minutes) | 10.00 |
| One-half hour (25-30 minutes) | 5.00 |
| Neurological: usual follow-up care and observation after diagnosis at original neurological examination: | |
| One hour (50-60 minutes) | 10.00 |
| One-half hour (25-30 minutes) | 5.00 |

CLINICAL LABORATORY TESTS

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| Blood counts, red, white and differential, including instrumental colorimetric hemoglobin estimation | 5.00 |
| Blood, smear for malaria | 2.00 |
| Urinalysis, routine chemical and microscopic | 2.00 |
| Blood, Wassermann (complement-fixation) | 3.50 |
| Blood, Kahn (precipitation) | 2.50 |
| Venepuncture and procuring of blood for serology without serological examination | 1.00 |
| Spinal fluid, Wassermann (complement-fixation) | 3.50 |
| Blood, complete chemical examination, including creatinin, urea, dextrose, nitrogen (or NPN), and uric acid | 15.00 |
| Sputum, plain smear for tuberculosis | 2.00 |
| Basal metabolic, determination of rate | 5.00 |

Doctors Tell Disaster Story

*Three small clinics bore brunt
of Texas City's ordeal*



It is 9:10 A.M. on April 16 in Texas City. For the ten physicians who practice there, just another fine spring day.

Surgeon Gerhard R. Manske, for example, has completed an early house call and is strolling toward the Beeler-Manske Clinic, where Dr. George W. Beeler, an industrial physician, is winding up a routine physical exam. Dr. Duncan R. Danforth, a G.P., is driving through the town's sun-washed streets on his way to the Danforth Clinic, where Surgeon Robert E. Casey is finishing off a tonsillectomy. Dr. Clarence F. Quinn, a pediatrician, smiles at a youthful patient in his office and tells him, "That's all, son."

The only cloud in the sky is man-made. It comes from the French freighter Grandcamp, burning fitfully at its pier. Doctor Manske sees it from the sidewalk, wonders idly about rumors that the ship is loaded with nitrates and ammunition.

Texas City's fine spring day ends at 9:13 A.M. With a fearsome thunderclap, the Grandcamp blows sky high.

Doctor Manske catches a glimpse of the waterspout rising 4,000 feet in the air before the concussion sends him sprawling on the sidewalk. Over his head whiz glass splinters, steel slivers, and bits of human flesh. He picks himself up, starts running toward the clinic. All its windows have been blown in. His colleague, Doctor Beeler, is dazedly picking up instruments that have been catapulted to every corner of the office. Hardly has Doctor Manske arrived when the first wave of victims converges on the clinic. Most wounds have been from flying glass.

Within five minutes, the Beeler-Manske Clinic is overflowing. Patients lie on the reception room floor, in corridors, on the lawn, on the sidewalk. The two physicians move from patient to patient, giving morphine and blood plasma, seeing that the victims are wrapped in blankets. Now and then, a doctor or nurse slips in the blood that streaks the reception room floor. For twenty-seven hours they work without a break.

When the Grandcamp explodes, Doctor Danforth's auto is pelted

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While piers became funeral pyres, Texas City M.D.'s treated blast victims.

with flying junk. Incredibly, he is not hurt. As soon as the first barrage has passed, he turns his battered car toward the explosion. He has driven only a few blocks when he sees the Monsanto plant burst into flames. A two-mile stretch of waterfront is already burning. He turns, heads full tilt for his office. He finds Doctor Casey already at work. Minutes after the blast the

Danforth Clinic (six beds, three bassinets) has nearly 200 patients. The injuries—compound fractures, burns, concussion, shock, blindness—remind the sweating M.D.'s of war at its worst. But this time hundreds of victims are children.

At the third of the town's small clinics, Twidwell-Schmidt, the same scenes are repeated. Three hours pass before outside aid begins to

"Experience has proven that babies who are given supplemental foods, starting at an early age, are physically superior to those limited to a milk diet."

The Basis of An Adequate Infant Diet

Excerpts from

"ALL ABOUT FEEDING CHILDREN"

by Milton J. E. Senn, M.D. and Phyllis Kraft Newill,
Doubleday & Company, Inc., Garden City, N.Y., 1945

"A CHILD'S FOOD has a tremendous job to do. It must provide material for growth and for the replenishment of the tissues he wears out every time he kicks or yawns. It must supply him with energy, keep him warm, and maintain his bodily functions in good working order . . . Thus we have the 'building foods,' or *proteins*; the 'energy foods,' which include *carbohydrates* and *fats*; and the 'protective and regulating foods,' which supply *minerals*, *vitamins*, *water*, and *roughage*. This

latter group consists principally of fruits and vegetables, but certain 'building' and 'energy' foods are also able to rate a place in this group and so are doubly important from a nutritional standpoint. Milk, meat, eggs, and whole-grain cereals are the outstanding examples of this ability to perform a dual function, and, together with fruits, vegetables, and fats, make up the list of so-called *essential foods* which form the basis of any adequate diet." (Page 48)

All the meat, and vegetables a baby requires ... combined in these 5 main-dish foods

These strained main-dish foods are supplements to milk in infant nutrition. Fed regularly, they meet all of a baby's requirements for *two* essential foods . . . meat and vegetables. A cereal is also added to each soup.

These soups are extremely palatable, and easy to feed. Vitamins and minerals are retained to a high degree. Strained smooth and uniform, they are well tolerated by even very young infants. Thus they can be prescribed as early as any strained foods. For more information, write: Campbell Soup Company, Camden, N. J.

Every grocer who sells Campbell's Soups can supply Campbell's Baby Soups



5 KINDS:
CHICKEN
BEEF
LAMB
LIVER
VEGETABLE

pour in. In that time the ten doctors of Texas City treat something like 1,000 patients.

"No buzz bomb could ever match this," says Mayor J. C. Trahan, a combat veteran. He appoints Doctor Quinn medical coordinator. Soon there is something to coordinate. Galveston, ten miles across the bay, where windows were shattered by the blast, has sent its medical community into action. Ambulances, police cars, trucks—anything that will roll—race toward the stricken town.

The Texas City jail, converted into a medical supply depot, is soon jam-packed. Doctor Quinn supervises the distribution of morphine, plasma, blankets. Red Cross relief crews arrive. The Army's 32nd Medical Battalion and Navy units also help lighten the load. Texas City's ten doctors are giving emergency treatment, then dispatching their patients to Galveston. Trucks

loaded with injured race along the roads from Texas City under a giant mushroom of smoke. Galveston's three hospitals get nearly 500 victims during the first five hours. The University of Texas School of Medicine halts classes. Professors and students go to work on the injured.

By midafternoon, the roads out of Texas City are clogged with walking wounded and with homeless families. Nearly every G.P. within fifty miles has arrived on the scene. Many of them set up improvised first-aid stations along the highways, and hundreds of dazed victims are treated there.

All night the doctors in Texas City work under a fire-red sky. In McGar's Garage 150 embalmers tie yellow parking tickets to the burned bodies, jot down identifying data, if any. An hour after midnight two more ships blow up in an awesome Fourth-of-July display.

[PLEASE TURN TO PAGE 75]

Power of the Press

A well-publicized wounded gangster was put in the care of an interne in our large municipal hospital. The interne was soon busy fending off batteries of news cameras aimed at his patient's door. Reporters hounded him, hung on his every word. The young doctor soon began to feel pretty important. When he arrived the next morning for breakfast, his fellow-internes were primed to deflate him. The opening barb was: "Well, Doctor, how is your distinguished patient this morning?"

"I don't know" he retorted. "I haven't seen the papers yet!"

—HENRY L. SKINNER, M.D.



REVOLUTIONARY NEW CASCO FOMENTATOR MAKES APPLICATION OF MOIST HEAT SIMPLE AND CONVENIENT

In conjunction with the 100% wetproof Casco professional model electric heating pad, the newly developed Fomentator makes wet heat therapy safer, more convenient, *more practical* for your patients. Easily sterilized, the Casco Fomentator retains moisture 10 to 12 hours under any of the 30 fixed-heats available on the heating pad, heats which can be dialed to precise specifications on the handy Nite-Lite switch. Complete with six professional accessories simplifying use of any form of medication. Performance-tested, Underwriters approved. At leading drug stores and surgical supply houses.



CASCO

Professional Model Electric Heating Pad With Revolutionary New Fomentator

A. Hospital slipcover—can be washed and sterilized. **B.** Fomentator holds moisture 10-12 hours under heat. **C.** Two washable flannel applicators for ointments. **D.** Two tie strips to fasten pad to any part of body.

CASCO PRODUCTS CORPORATION, BRIDGEPORT 2, CONN.

But the next day Doctor Quinn is able to announce the medical situation "under control." Another twenty-four hours and the fires, too, have been checked. Out-of-town volunteers help restock the clinics, repair the blast damage. Texas City's practitioners pause for their first deep breath. Since the first explosion, some 4,000 victims have been treated; over 500 have died.

That's the disaster story, as Texas City's physicians pieced it together for reporters from this magazine soon after the blast. Their ordeal gave them many hard-won ideas for coping with such emer-

gencies. As a result, they've set up an emergency disaster unit headed by Doctor Quinn. They'll see that ravaged Texas City is ready for the next catastrophe to come its way. And they'll pass their findings along to M.D.'s in other cities as an aid when disaster strikes.

But most of their advice will deal with the first few hours. After that, modern communication and transportation bring an abundance of outside aid. "We finally had more doctors than there was work for them to do," a Red Cross director reports. "I have never seen such a response." —R. C. LEWIS

Group Practice Council Gets Under Way

Why not a national organization of private medical groups? That question, often asked, gave promise last month of stimulating some action.

Several New Yorkers under the leadership of Dr. Lester C. Spier had formed the Group Medical Practice Council of the Metropolitan Area. Their organization was a purely local one, but it might set the pattern for similar councils in other centers. If that came about, a national council would be a logical expectation.

While set up for the purpose of furthering group practice by any legitimate means available, the New York council would, in the beginning, serve mainly as a clearing house of group practice information. As such, it could be expected to advise physicians about the formation of medical groups and to assist those who had already started groups to operate more effectively. A series of original studies of group operation is planned.

The New York council is to be representative of most types of group practice: private, industrial, [PLEASE TURN TO PAGE 76]

hospital, university, and prepayment. Whether diagnostic groups will be included remains to be settled. Although five meetings have been held so far and the organizational structure has been completed, an estimated \$200,000 will be needed to start operations. The founders say they have reason to expect the financial support of one or more philanthropic foundations.

Acting Chairman Spier is a member of the public relations committee of the New York County Medical Society and is himself a group practitioner. The public at large knows him as "Doctor Weldon" of ABC's network program, "Tell Me, Doctor" (238 stations, 167 consecutive broadcasts).

Most members of the council who were interviewed recently seemed opposed to socialized medicine. However, they have invited both rightists and leftists to their meetings. They have also invited members of different professions, businessmen, reporters, and others.

Previous efforts to organize a group practice council were made by Medical Administration Service, a Rockefeller-supported agency with headquarters in New York City, under the direction of Dr. Kingsley Roberts. Several meetings were held but the project did not take hold, probably because the

sponsoring organization included in its directorate such men as Michael M. Davis who, for years, had urged the adoption of compulsory sickness insurance. The new council seeks to be representative of all points of view, deriving its major impetus, however, from representative physicians who are members of organized medicine.

The New York County Medical Society is on record as approving group practice. It is presumably sympathetic to the Group Medical Practice Council of the Metropolitan Area. On the other hand, the council has not sought medical society approval and probably will not seek it until a record of accomplishment can be shown.

Regardless of its relationship with organized medicine, the council intends to function as an independent unit. It has invited the participation of all physicians engaged in or interested in group practice in the New York metropolitan area.

Although a Conference of Clinic Managers (business managers of private medical groups) has been in existence for a number of years, the Group Medical Practice Council of the Metropolitan Area is said to be the only such association of group physicians now functioning in the United States.

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For those whose business or pleasure trips may be marred by seasickness, airsickness, trainsickness or carsickness, VASANO is indicated because of efficacy and proven safety in therapeutic dosage. Available on prescription as tablets and, for those unable to undertake oral therapy, as suppositories.



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PACKAGING: VASANO Tablets, 0.1 mg. hyoscine (scopolamine) camphorate with 0.4 mg. hyoscyamine camphorate, boxes of twelve;

VASANO Suppositories, 0.2 mg. hyoscine (scopolamine) camphorate with 0.8 mg. hyoscyamine camphorate, boxes of 10.

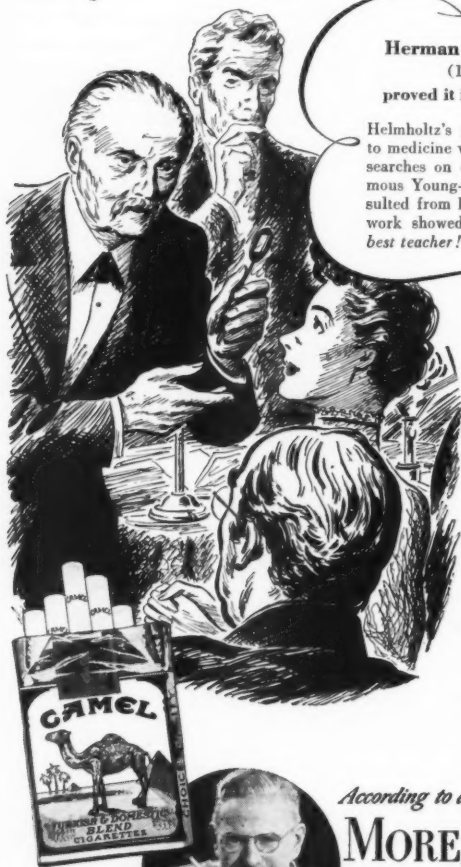
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Revise the G.P.'s Role

[Continued from page 55]

"I would like to see a G.P. examined before a 'specialty' board every ten years. He would be examined not in the things he learned at medical school but in the new things that have happened since then. You could have each family doctor examined by two internists, an obstetrician, and possibly a surgeon (to find out whether he knew as much about surgery as a Boy Scout ought to know). That type of examination could be rapid but searching.

"If you are going to get G.P.'s to keep up, you need a reward for doing so and a penalty for not. Certification as a family doctor, or the lack of it, would serve in both capacities."

If steps like these are taken, the term "general practitioner" may soon acquire new meaning; that it's far from clear now needs little documentation, says Dr. Henry B. Makover. "I have found physicians who called themselves G.P.'s doing everything from major surgery to internal medicine. Just recently I heard a certified internist refer quite seriously to another certified internist as a 'general practitioner.' Why? Because the second man made house calls."

Many forecasters predict a medical future centering around comprehensive service and group practice. "The general physician," says Doctor Makover, "will be the quar-

terback of the team. He will know when to use a specialist on referral and, more important, when not to use one. He will be a true family physician, indoctrinated with the social aspects of medical care."

Dr. Dean A. Clark adds: "The new type of general physician will not be the jack-of-all-trades we now call a G.P. Instead, he will have the broadest medical knowledge. He will be able to understand the implications of any type of illness, while deferring in many instances to his specialist colleagues for the technical dexterity to clinch the diagnosis or to furnish treatment.

"He will be the physician most aware of what good health is, as distinguished from mere absence of disease. He will take the steps necessary to prevent illness, or to see that it is treated in its earliest possible stages. Above all, the new general physician will be the family's personal physician, the doctor they seek in time of trouble, the person upon whose advice and treatment they rely.

"But he will not be working alone, in competition with all others. He will be working with colleagues, so that his patients may have the benefit of the most comprehensive knowledge available.

"This kind of G.P. is not to be relegated to an inferior professional and economic position, as a feeder for specialists. He will hold the very center of the medical stage, the place of highest respect from physicians, and patients alike."



This non-messy ointment kills fungi and bacteria rapidly.

FOR STUBBORN "ATHLETE'S FOOT" *New, Double-Action Fungicide*

Trimethyl

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Pentachlorophenate

(2.2% Emulsion)

You can effectively treat stubborn cases of "Athlete's Foot" with T.C.A.P. Ointment. Note these points:

1. Rapidly kills fungi causing "Athlete's Foot". Fungicidal action extends over a wide pH range.
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1. MacKee, Sulzberger, Herrmann and Karp. J. Invest. Dermat. 7:175 (1946).

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Academy, After 4-Year Study, Warns Against Compulsory Medicine

*Report, cited for its objectivity,
favors voluntary insurance*



When fifty experts spend fifty months on a research job of national importance, their findings are likely to be worth reading. And those of the New York Academy of Medicine are.*

In February 1943 a Committee on Medicine and the Changing Order was launched by the academy "to study present trends in medicine." One of its chief conclusions, recently released, is that "Voluntary prepayment plans are much safer and more adaptable than compulsory insurance, the consequences of which are at best uncertain . . . It is on a voluntary basis that the great progress in medicine has been achieved . . ."

The committee was composed of thirty-three physicians and seventeen representatives of allied professions and the laity. It derived its support (\$54,000) from the Commonwealth Fund, the Milbank Memorial Fund, and the Josiah Macy Jr. Foundation.

According to Dr. Malcolm Goodridge, chairman of the committee,

*See "Medicine in the Changing Order," 1947. The Commonwealth Fund. New York. \$2.

information and opinions were sought from a variety of authorities. "Those consulted represented every shade of economic, social, and political conviction . . . In all, some fifty men and women addressed the committee in a period covering sixteen months." Topics discussed included economics, sociology, industry, labor, insurance, public health, the hospital, rural medicine, nursing, dentistry, medical education, and research.

The committee also selected the titles and authors of a dozen monographs that have been published in its behalf by the Commonwealth Fund. "The factual material contained in these monographs," says Doctor Goodridge, "was utilized to a considerable degree in shaping the report of the committee's study."

No study quite like the present one has been made before. Its object was to examine the existing body of fact and opinion, to evaluate it, and then to prepare recommendations. Previous research, such as that of the Committee on the Costs of Medical Care (1928-32)

The Doctors' Album of New Mothers

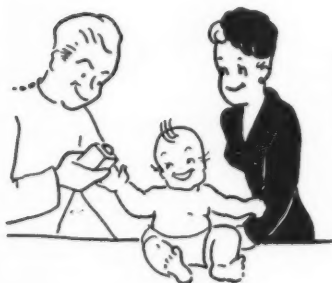
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Mrs. Ewald is an eager-beaver. Eager to make friends and go about socially, as well as produce offspring!

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But it doesn't occur to her that this fretting and anti-social activity might be the result of chafing and diaper-rash discomfort.



Finally her doctor, consulted, suggests dusting her little rebel with Johnson's Baby Powder.

Johnson's Baby Powder helps relieve diaper rash, chafing, prickly heat.

More doctors and nurses recommend Johnson's than all other brands of baby powder put together!

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and of the National Health Survey (1933) also led to recommendations; but much of the work of the investigators was ringing doorbells and helping to compile masses of original statistics. What's more, the earlier studies were directed largely by laymen while those of the New York Academy of Medicine were made under the aegis of physicians.

Several attacks were made on the academy following publication of the report of its committee. One stemmed from the apparent fact that some newspaper reviews had been based on a reading of only the introduction to the report and that in the introduction the committee's attitude toward health insurance is expressed, unfortunately, in what sounds like so much double-

talk. This led to an impression that after four years' study, the committee didn't know *what* it believed and was trying to weasel out of an untenable situation. Actually those who went on to read the recommendations in the last chapter got quite a different—and a much clearer—understanding of what the committee approves and disapproves.

Some of the charges leveled at the committee for its choice of consultants were also the result of superficial observation. One critic called attention to the presence on the consultants panel of such men as Carter Goodrich of the International Labour Organisation; George Soule of The New Republic; Max Lerner of PM; Dr. Henry Sigerist, who wrote the book, "So-





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cialized Medicine in the Soviet Union"; Dr. Ernst Boas of The Physicians Forum; Julius Emspak of the CIO; George Perrot of the Public Health Service; and Dr. John Peters of the Committee of Physicians for the Improvement of Medical Care. It was implied that men like these were in the minority (but purposely present so that, as the committee has said, all points of view would be represented).

Another job was aimed at certain of the committee's writers. Bernhard J. Stern, for example, who wrote three of the committee's dozen monographs, was described, with documentary citations, as a leading member of the Communist Party and as having testified before a Senate committee that only national health insurance could meet the medical needs of the American people.

If Stern is as described, it may be too bad that someone else was not selected for the work assigned him. On the other hand, it is to be emphasized that Stern's monographs are almost entirely factual. Few opinions are expressed and in no cases noted are they arguments for compulsory health insurance. The same carefully objective reporting is evident in a monograph by Nathan Sinai, another advocate of Federal medicine.

The report of the academy contains recommendations and observations on many important medical-economic issues besides health insurance. It will no doubt be put

to a variety of uses by organized medicine in its campaign to educate the public. It is also expected to be of value in influencing medical legislation, having been scheduled for use as a reference at hearings on such measures as Sen. Robert Taft's National Health Bill of 1947 (S.545).

INSURANCE PROPOSALS

Before the recommendations of the academy relating to hospital service, public health, medical education, health centers, Government aid, and other problems, are summarized, a few more of its conclusions on medical insurance deserve quotation. Here are several (condensed):

"The Committee on Medicine and the Changing Order concludes that compulsory medical insurance could not realize the promises made for it and would inevitably create new evils of its own. Any scheme of compulsory medical insurance *at this time* would lead to most unfortunate results.

"Schemes for prepayment of medical costs by the enactment of compelling legislation and the collection of tax monies are deceptive in their simplicity. Although under compulsory medical insurance on a nation-wide scale a larger number of people receive medical service, the quality of service tends to decline.

"We know from European experience that under national compulsory medical insurance, even as the general level of medical prac-

tice is lowered, its costs are raised. A system of compulsory insurance presages the establishment of a vast and costly administrative machine. It would burden medicine with an overhead many times its present size and unlikely to yield benefits commensurate with its cost."

There is in social insurance systems an inevitable trend toward centralization, says the committee: "In the beginning, the authorities usually make concessions to local and state governments because granting such concessions is the most effective way of stilling opposition. Before long the national authorities become irked by the limits on their powers and ascribe every difficulty to the existence of decentralized administration. They begin to press for the nationalization of the whole system of social insurance. Since the government holds the purse strings, national officialdom soon has its way. In time, therefore, the benefits of local autonomy—flexibility, adaptation to local needs, and local responsibility—are discarded.

"As compulsory insurance becomes established more and more decisions are made in accordance with a body of formal rules. Individuals and problems are treated in bulk and the administration becomes progressively depersonalized.

"Together with rules and bulk treatment goes standardization. The mere size of the compulsory enterprise and the unavoidable preoccupation with an infinite number of details force even farsighted administrators to fall back upon generalized solutions of individual problems. Hence many social insurance plans develop imperceptibly into systems of organized relief."

The committee says no reliable estimates of the cost of compulsory health insurance are now available. Reasons given for this are that no one has yet produced a satisfactory definition of "adequate medical care" and no one knows how the cost of a compulsory scheme would be influenced by its beneficiaries, its doctors, and its administrators.

The only cost estimates the committee includes in its report differ by some \$3 billion, thus°:

| | |
|--|------------------|
| 1. Based on Senator Wagner's figures | \$11,625,000,000 |
| 2. Based on Tax Foundation Study | 11,787,000,000 |
| 3. Based on Muntz estimate | 13,405,000,000 |
| 4. Based on Hirschfeld's study | 14,625,000,000 |

"These are initial estimates," says the committee, "and as such they furnish little clue to what the experiment would cost five or ten

*Taken from Earl E. Muntz' "Proposals for Health, Old Age, and Unemployment Insurance." 1946. American Enterprise Association, Inc. New York.

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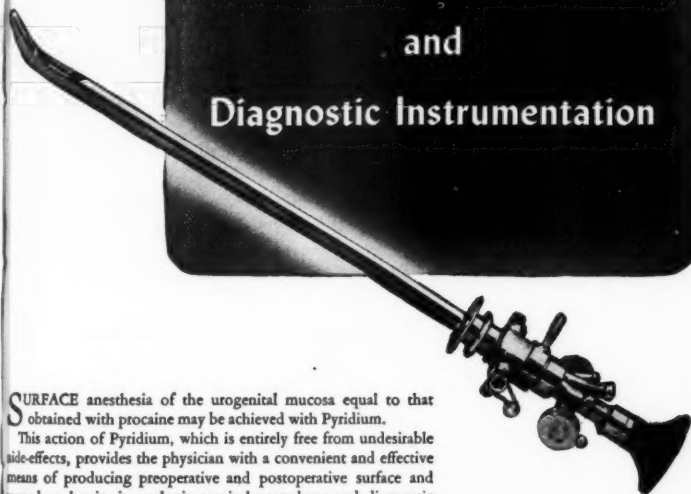
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years later. For a variety of reasons the cost, large as it is at first, is bound to increase."

The committee says compulsory social insurance has been publicized as merely a device to *spread* existing costs, but that actually it serves to *raise* costs as well. "Once the country commits itself to this type of legislation," it warns, "it cannot retrace its steps. Promising experiments to solve the problem in other ways will be abandoned, because everyone will be busy setting up a massive new administrative machinery and distributing huge funds. Experience in foreign countries shows that the difficulties encountered in administering these plans are dealt with usually by means of a patchwork of amend-

ments and executive orders which rarely go to the roots of the trouble."

The committee believes that "Medical insurance is essential in solving the problem of medical care distribution." It admits that "Compulsion by government would accelerate the extension of insurance to all the people." It admits, also, that "Voluntary insurance will spread only slowly and incompletely among the low-income families." It is at the same time convinced that "Voluntary insurance provides flexibility for local initiative and is designed to encourage new and better methods of organized medical services, such as group medical practice." It conceives voluntary insurance as "an essential experiment in

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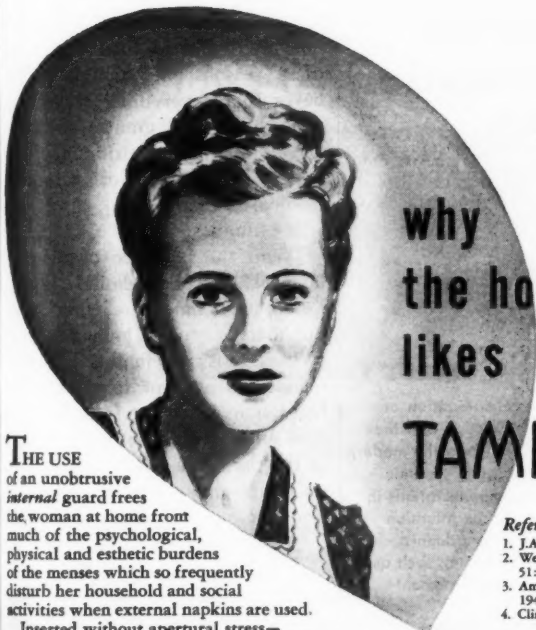
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References:

1. J.A.M.A., 128:490, 1945.
2. West. J. Surg. Obst. & Gyn., 51:150, 1943.
3. Am. J. Obst. & Gyn., 48:510, 1944.
4. Clin. Med. & Surg., 46:327, 1939.



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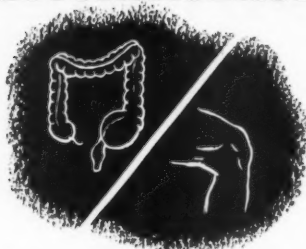
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1. Bassler, A.: *Med. Record*, 153:20, 1941.
2. Osgood, H. A.: *Connecticut M. J.* 5:28, 1941.
3. Pemberton, R.: *Rev. Gastroenterology*, 9:91, 1942.
4. Speckman, R. W. et al.: *Am. J. Med. Sci.*, 202:68, 1941.

prepayment, which avoids the pitfalls of compulsory insurance.” For these reasons the committee believes that “everything should be done, by way of grants, subsidies, and employer contributions, to hasten the growth of voluntary medical insurance.”

It continues:

“With the evidence of unequal medical care so definitely established, it is a natural reaction of the public to demand an immediate corrective. It is also in the American manner to attempt to do this by legislation. [But] far from being a sure solution, this method is a leap in the dark; the results are at best uncertain—may even be disastrous—and in any event are irrevocable.

“The recommendation made by our committee envisages the development of a slower but much surer program. If such a plan can obtain the cooperation of the public, the profession, and the Government, it will much more surely lead to the distribution of comprehensive medical care of a high quality to all the people. It is thus that the great progress in medicine has been achieved in the past, and it is thus that continuance of this progress can best be assured.”

OTHER PROPOSALS

Apart from its recommendations on medical insurance, the committee offers a comprehensive list of other proposals. Here they are (condensed):

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in the regimen of the CHRONICALLY ILL..



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*Osgood, R. B., *Body Mechanics and Posture*, J.A.M.A. 96 : 24 (June 13) 1941.

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tion of health. It should make these benefits available to the entire population. Medical service is not now optimally organized or distributed. Plans for its improvement should be preceded by inclusive study of the many complex factors involved and should not be directed toward the support of any preconceived scheme.

"In a country as vast as ours no one plan can be applicable to all parts. Experiments for extending and improving medical care in conformity with local conditions are urgently needed.

"The general public, as the intended beneficiary of plans for change, has such a vital interest in them that it should be adequately represented in their formulation. But physicians, who in the last analysis must render medical care, should have a dominant role in the preparation of plans they will be called upon to carry out.

"Gradual extension and improvement of medical service is preferable to revolutionary change. While government has a direct responsibility for the health of its citizens, rapid and sweeping changes accomplished by legislative action would defeat their own purposes by impairing the spirit and quality of a service which is essentially individualistic.

"As a result of its study the committee proposes several conditions which it believes are necessary for satisfactory improvement of medical service:

"Quality of medical service must be preserved. Extension of inferior service will at best be of limited value and under certain circumstances may be actually dangerous . . . Changes should be accomplished as far as possible without dismemberment, disorganization, or serious dislocation of any major section of the medical profession.

"Provision of public health services is a prime essential. Great areas of rural America as well as many of its smaller cities are still without adequate public health services. Correction of this condition is essential. The committee urges, however, that this step be regarded as a local responsibility to be shared with state and federal agencies only where and when local resources are inadequate.

"Improvement in medical service requires effective use of hospitals with adequate facilities. There must be more hospitals. Those which exist must be more effectively utilized. This implies development of better outpatient department clinics and the use of hospital facilities by groups of physicians to reduce the costs of medical service. By such arrangements large items of capital investment and the failure to use in full the facilities available, now implicit in the office practice of individual physicians, may be eliminated. Under these circumstances the committee favors the experimental development of diagnostic consultation services at a minimum flat fee, the services to be provided



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"Success will require trained professional and non-professional personnel. Progress in improving medical care will be slow until the requisite professional skill has been attained. The difficulties of rapid progress are particularly apparent in rural communities. Younger and better-trained physicians tend to settle in large cities. Correction of the deficit will depend in part upon better financial rewards, but perhaps more upon the provision of resources essential to effective medical practice and upon education of the community in the desirability of adequate medical care.

"There are several ways to assure more adequate income, ranging from participation in a group serving a prepayment plan to partial subvention in the form of a salary for part-time service to the medically indigent.

"In sparsely settled regions the committee recommends a variety of experiments such as local health centers with emergency bed facilities, mobile clinics, mobile laboratory facilities, and airplane ambulance services. Exposing medical students during their clinical years to rural practice should be achieved through an association between the medical schools and the rural hospitals.

"Cooperation of physicians is required. The medical group, now well established in this country, offers advantages which cannot be attained by the individual. Coop-

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erative enterprise among physicians working in a health center with facilities for curative and preventive medicine seems to offer an appropriate formula for rapid progress. For its accomplishment, however, organization is required and with it some sacrifice of the individual prerogatives of each of the cooperating physicians. For successful operation there must also be strict standards of performance to be followed by all the individuals engaged in the enterprise.

"Reduction in the cost of medical services is strongly urged to meet the needs of the medically indigent. The committee recommends the extension of voluntary prepayment plans which, by spreading the risk, can make this group competent to

provide for its medical needs. To assure the stability and solvency of such prepayment plans, the committee urges that they should provide easy admission for the economically higher groups, the latter being generally better insurance risks. The committee also recommends that the indigent likewise be covered by the insurance of prepayment plans, the community paying the premium.

"The goal should be comprehensive medical service, including preventive as well as curative treatment. Segmental care as represented by diagnostic clinics or clinics for case-finding in a special disease will not suffice. The discontinuous care and patchwork now represented by hospitalization without

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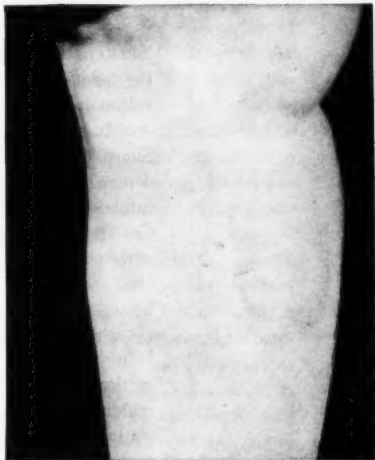
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adequate follow-up will furnish only a partial solution. Examinations should not depend solely upon the accident of illness. They should be undertaken when no fault is apparent and should be sufficiently searching to permit early recognition of cancer and important infectious diseases such as tuberculosis and syphilis, as well as emotional abnormalities.

"Routine care should include procedures for immunization. The treatment should be focused not only on the care of the acutely ill or injured person but should also include management of convalescence and rehabilitation.

"Extensive education for both physicians and the public will be required. Few physicians are now equipped to practice both preventive and curative medicine or to conduct routine health surveys. To make comprehensive health care on a large scale a reality, medical schools will be required to give the physician in training a new orientation. Progress will depend upon improvements in the curricula of medical schools, the recruitment of competent student bodies, and the continuing education of the physician.

"There must also be education of the public. Few patients at present are ready to take advantage of comprehensive medical service. Much information will be required before people realize the advantages of hygiene, proper nutrition, and constant medical supervision in health as well as in illness. Extension of

the best medical service demands physicians with more than ordinary interest in both preventive and curative measures.

"Government aid will be required. In general, the system of government grants-in-aid for the promotion of better medical care has been successful. It has the impressive advantage of allowing for local administration and experimentation to meet special conditions. It is applicable to the establishment of hospitals and health centers, to the support of group practice, and also to the support of voluntary plans for prepayment medical insurance. In general the committee supports the grants-in-aid method of government contribution to the solution of many of the problems of medical care as a sound alternative to legislation for an over-all program of compulsory health insurance . . .

"Over and above the specific conclusions the committee derives from its studies and upon which it based its numerous particular recommendations, the committee stands confirmed in the conviction that providing more and better care for the people will require many years for its achievement.

"It is hoped that some permanent agency may come into being which will carry into the future the continued study of the problems of medical care. This report may serve as a preliminary introduction to such a continuing study."

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Educational Benefits Seen as Major Attraction of Group Practice

Solo physicians said to lack same incentive for p.g. study



"Physicians are trained for years by the techniques of group practice. Then most of them go out to practice in individual offices. There they are unable to use the teamwork methods they have learned so thoroughly," says Dr. Dean A. Clark.

The tie between medical education and group practice is of long standing, he adds, pointing out that "for almost half a century all medical education in America has been conducted exclusively through group practice."

"This is no trick play on words. Since the 1890's, practically every medical student here has been trained with a group of physicians as his teachers—a group that worked together as a team and that utilized in common the physical plant and the assisting personnel necessary to teach good medicine."

What draws physicians into group practice today? Probably most converts are won by its remuneration, usually well above the all-physician average, or by the expectation of superior working conditions. But M.D.'s assembled* a

month ago agreed that a group's educational benefits are also among its most important attractions.

Although the medical school version of group practice sets a wholesome example, it has serious limitations, Doctor Clark believes. "In a social sense, the teaching group is usually sterile and irresponsible. With few exceptions, it is a medical group only in the technical sense. Though the team-work is there, most physicians on the team do not depend on the group for the major part of their livelihood."

Despite failure to capitalize on all its advantages, group practice contributes heavily to the doctor's continuing education, the conferees agreed. Dr. Leslie K. Sycamore points out how the group member benefits professionally: "Constant association and consultation with the other members stimulate professional interest and pride. They challenge each physician to keep thoroughly informed in his field."

Groups often whet enthusiasm for continued learning through required study programs, he notes.

[PLEASE TURN TO PAGE 104]

*See introductory box, page 52, this issue.

From where I sit ... by Joe Marsh



Sam Hackney Reports on the U.S.A.

Sam Hackney and the missus just returned from a trailer trip around the country. They're tired, and glad to be home, but mighty impressed with what they saw.

As Sam reports—every section has something different; a different way of talking; different tastes in food and drink; different laws and customs. But bigger than all these differences is the American spirit of tolerance that lets us live together in united peace.

"Of course," says Sam, "you run into *intolerance* from time to time. Individuals who criticize another's right to speak his mind; enjoy a glass of beer; or work at any trade he chooses. But those are the exceptions—and we're even tolerant of them!"

From where I sit, more of us ought to make a trip like the Hackneys—to realize firsthand how America is bigger than its many differences... how *tolerance* of those differences is the very thing that makes us strong.

Joe Marsh

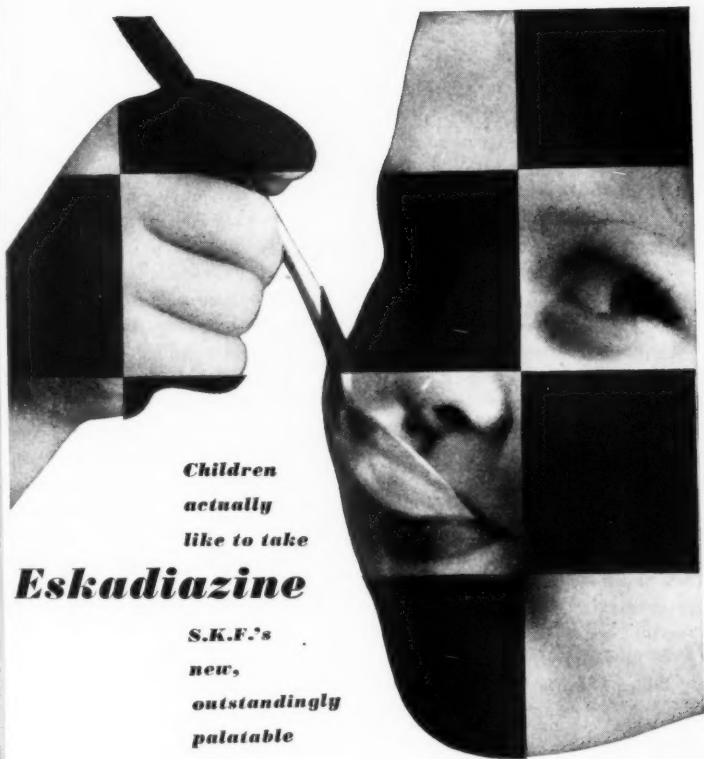
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Frequently on members' "must" lists are trips to medical centers and medical conventions. These excursions are possible, Doctor Sycamore points out, because "group patients are under competent care during any one doctor's absence. Also, the group physician suffers no financial loss. By contrast, the solo practitioner often finds it difficult to escape from his practice. When he does get away, he must face the actual expense of his clinical trip, some loss of income, and possible loss of patients."

Groups can serve to educate not only members but also solo physicians in the area, Doctor Sycamore believes. Two good means of contact with local M.D.'s are case discussions with referring physicians and case letters sent to them when the patient is discharged from the group, he says. "In this way the patient's family doctor gets a composite and competent opinion on both diagnosis and treatment. Educationally, it's sure to help him."

Actually, the professional benefits of group practice are said to go beyond diagnosis and treatment. One such benefit is described by Dr. Ozro T. Woods: "I am very much impressed with the experiment of pushing academic medicine into a place of responsibility for the care of people, as has been done in V.A. residency programs. It is the most stimulating experience I have had in medicine. The group type of medical practice is what makes the difference."

[PLEASE TURN TO PAGE 106]



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Eskadiazine — a new *fluid* sulfadiazine for oral use — is so palatable that children actually like to take it. Parents, too, are grateful to be relieved of the chore of crushing tablets and coaxing a sick child to swallow an unappealing mixture.

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*Flippin, H. F., et al.: Am. J. M. Sc. 210:141-147, 1945.

Smith, Kline & French Laboratories, Philadelphia, Pa.

Group practice also helps the prepayment effort, says Doctor Woods, declaring that the reverse is true, too: "The one thing that is going to develop group practice faster than anything else is prepay medicine. We've seen that in our own medical service plan in Dallas. It doesn't work as well as if subscribers were cared for by groups, and we know that. There's a lot of waste effort."

Doctor Woods feels, moreover, that groups exercise leverage on professional standards by continued improvement of the caliber of member-physicians. "Good groups have realized that the only way they can improve is to build from the bottom," he says. "You can't build a clinic from the top; the physicians who are there tend to deteriorate. It's the new men who raise the professional level. So good clinics recruit better doctors than they have in the group already."

Before the war, some groups had difficulty signing up high-caliber M.D.'s. Not so now, it is reported. Most groups are said to be receiving many more applications from would-be members than they can handle. Nearly all applicants, the groups report, are men who have had top-flight training.

Dr. Alfred Angrist sees the group as a white hope for G.P.'s. "If you

can integrate the general practitioner into a group," he says, "you assure him a continued education. If you isolate him, he is going to be forlorn. That means, sooner or later, a depressed type of service to the patient."

Increased recognition of the group's effect on professional standards is said to be indicated by several recent experiments. Milwaukee's Columbus Hospital, for example, is fostering the group idea among staff members even though they don't "office" together. For a token fee, the hospital provides physical facilities. There a doctor can see his own patients in consultation with any other physician in the hospital. Dr. William A. O'Brien calls such a plan "the best teaching service any hospital could have."

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1. Jacobson, M.: Preliminary report on the combined effects of vitamin B complex with amino acids, N. Y. State J. Med. 45:2079-2080 (1945).
2. Ruskin, S. L.: The role of the coenzymes of the B complex vitamins and amino acids in muscle metabolism and balanced nutrition, Am. J. Digest Dis. 13:110-122 (1946).

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Medical Schools Urged to Provide Complete Health Services

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"Medical schools must go into the business of treating patients," says Dr. Dean A. Clark. Why? Because "medical education today has two serious inadequacies:

"1. It fails to bring the benefits of modern medical knowledge to the whole population.

"2. It fails to train physicians with an appreciation of their patients' personal problems."

Explaining at a recent meeting^o the disorders that afflict medical education, he said, "Teachers and students rarely feel responsibility for the general health problems of their patients. This holds true whether they're dealing with the low-income public or with private patients.

"Nearly all our teaching institutions show full responsibility only for the disease the patient happens to have at the time. Rarely do teachers and students care for the minor illnesses of the patient, or see him in his home, or give him general health supervision. The patient's family problems, his economic status, his social relationships,

and his emotional difficulties are not considered seriously. Almost non-existent is any feeling of responsibility for making first-rate medical service available to all who require it."

These factors, Doctor Clark believes, cause medical schools to turn out physicians who cannot handle the family's medical problems as well as might be expected. "Giving the student a thorough grasp of modern techniques is not enough," he says. "It may make good technicians; it can never make good doctors. To do that, teaching institutions must give their students an understanding of what health service means in its entirety."

How can that be done? Doctor Clark thinks the answer is two-fold:

¶ "Our schools and hospitals must step off their pedestals and take full charge of their patients' health. Home service must be as much a part of their task as service in the clinic."

¶ "The next step is for the schools and hospitals to offer com-

[PLEASE TURN TO PAGE 111]

^oSee introductory box, page 52, this issue.

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prehensive services to all who desire them, rich or poor."

Expanding the medical schools' scope would be "simple enough," he says: "All it would require is a slightly larger staff, an automobile, some gasoline, and a good unit record system." Such an innovation would, in his opinion, act as a tonic on students and patients. "For the medical student, nothing would be more salutary than to learn what it means to be a family's real doctor, aware of all its problems and fully responsible for its health," he says. Under such a plan, "patients would begin to lose their feeling that teachers and students are just faces in a bewildering medical maze."

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But he warns that to make teaching medical services comprehensive is only the start. "True, that step would begin to make the school or hospital a part of the community. But if comprehensive services were limited to those eligible for charity, the student would see only what statisticians call a 'biased sample.' He would not yet be getting what medical education should give him: an understanding of the needs of *all* groups in a modern community."

That a number of private practitioners may be allergic to his formula, Doctor Clark admits. "Some say that teaching and research cannot be carried on with pay patients," he says. "Others feel that it would represent unfair competition with practicing physicians and non-teaching hospitals. But the University of Chicago and the Mayo and

Lahey Clinics have shown that it can be done brilliantly. They have shown that accepting all classes of patients improves the professional standards and economic status of the entire medical community."

When comprehensive service is extended to all, regardless of income, who pays the bills? Says Doctor Clark: "It might be accomplished in a small way through philanthropists or foundations. Or it might be done with tax support, as it is done moderately well for soldiers, sailors, veterans, and merchant seamen."

"But neither of these means alone would meet the present temper of our people. They do not want charity; they want rather to pay their way according to their ability to do so. This they can do under the insurance method, combined with tax support for those who cannot meet the full costs of insurance. The teaching institution would gain by making its comprehensive, group practice service available through medical care insurance."

Would students in such schools see a sufficient variety of cases? Doctor Clark thinks so. "Other medical groups could be selected to send complex cases to the teaching center for diagnosis or treatment," he suggests. "Referrals would be facilitated by payment based on the capitation plan; financial disadvantages in referring patients from one group to another would thereby be minimized."

Schools could also bring to light

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unusual cases by starting medical service departments for industry, veterans, or crippled children, he explains.

"Thus the teaching institution would become the community's medical center in the best sense. It would not draw away from other physicians the cases they are wholly competent to manage. Instead, it would stand as a major professional resource for the entire medical community."

The school could also offer its aid as a diagnostic center for community physicians, he believes. For a successful pattern, he points to the consultation services run by the Johns Hopkins Hospital and by New York's Mount Sinai Hospital. But diagnostic centers cannot stand alone, he cautions; if they do, they may be harmful rather than helpful as an educational technique.

Unless they are linked with a

comprehensive service program, they may "engender the very attitude of impersonality and non-responsibility we are trying to remedy."

Is this proposal a practical blueprint for medicine's future? Some educators, convinced of the invigorating effect it would have on medical students, say yes. Many private practitioners, wary of encroachment on their own practices, say no.

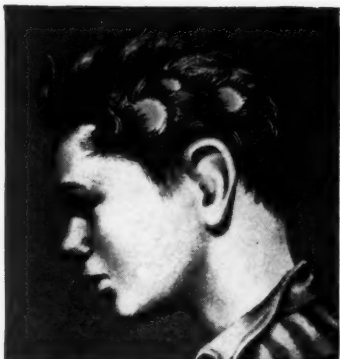
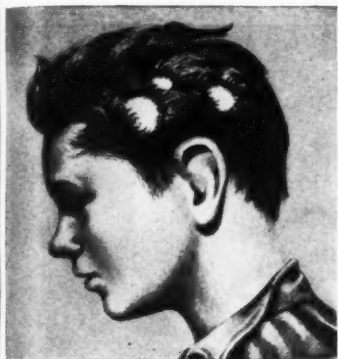
But both sides find plenty to think about in Doctor Clark's summation: "We can have up-to-date, well-trained doctors if we want them—but not by accident. We must begin to prepare them now among our students, our hospital staffs, and among practicing physicians too. This preparation can be successful only if we link comprehensive service with medical education."



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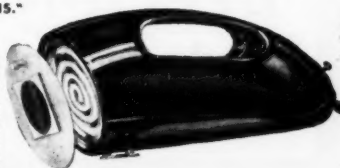
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A. When a person insists on speaking to the doctor, the secretary should refuse the request tactfully but firmly until she knows the purpose of the call. A conversation like this may then ensue:

Caller: May I speak to the doctor?

Secretary: Who is calling, please?

C. This is Mrs. Baker. I want to speak to the doctor.

S. This is Doctor Coe's secretary. Perhaps I can help you.

C. Isn't the doctor in?

S. Yes, Doctor Coe is in, but he is busy with a patient and has asked me to handle whatever telephone requests I can. Do you wish to make an appointment?

C. Yes, I want to see the doctor as soon as possible.

S. I can make an appointment

for you tomorrow morning at 11 o'clock. Will that be convenient?

Frequently the only reason a patient phones is to make an appointment. He forgets that it is the secretary's job to handle such details. A firm but courteous reminder saves time for everyone.

The matter is a little more complicated when the caller refuses to give even his name and demands to speak to the doctor on a "personal" matter. A person who is really a friend of the doctor won't hesitate to tell his name. When a caller does hedge on telling either his name or the reason for his call, he does so probably to gain an advantage for

► Questions from physicians and secretaries about business procedures in the medical office are answered here, as space permits, by Miriam Bredow. She is the author of "Handbook for the Medical Secretary" (McGraw-Hill) and Dean of Women, Eastern School for Physicians' Aides. In private life, she is Mrs. Heinrich Wolf, wife of a New York physiatrist.

himself. This is true particularly when the person assumes a tone of authority, implying that if he does not talk with the doctor at once he'll raise the roof about it. Many a new secretary becomes frightened and calls the doctor to the telephone. Later she discovers he was interrupted unnecessarily and had to turn down tickets for the Fireman's Ball.

Here's how a secretary can handle such cases:

Caller: I would like to speak to Doctor Coe.

Secretary: Who is calling, please?

C. This is a personal matter.

S. I am sorry, Doctor Coe is busy with a patient. I can't disturb him unless I know your name and the reason for your call.

C. I told you it was a personal matter. Now will you connect me without further delay?

S. Do you want to make a professional appointment?

C. No—I want to speak to the doctor.

S. I'm very sorry, I can't disturb him. If you can't tell me why you wish to speak to him, perhaps you'll be good enough to write Doctor Coe and explain what you wish.

Such an approach usually produces the desired results. The caller, seeing that he can't speak to the doctor unless he identifies himself,

will give the reason for his call.

You need not fear that your employer will miss an important call if you refuse to connect such a caller. Any professional man who has something important or confidential to discuss with the doctor will say so clearly. If he identifies himself as a doctor, connect him without further questioning.

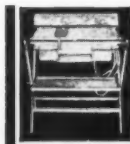
The secretary of another physician will call occasionally to ask whether the doctor is in; her employer wishes to speak to him. Connect your doctor's telephone after the other doctor is on the line. It's usual for the person making the call to wait.

—MIRIAM BREDOW

Anecdotes

¶ **MEDICAL ECONOMICS** will pay \$5-\$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Contributors may remain anonymous upon request.

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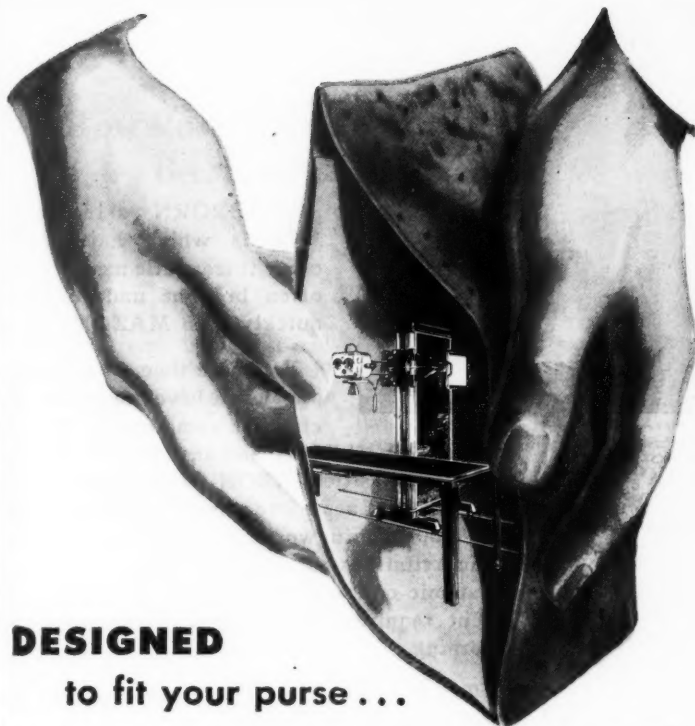
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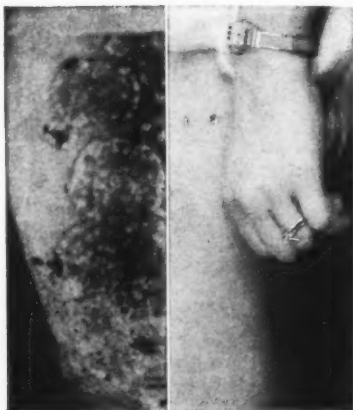


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How Post-graduate Education Can Be Made More Practical

*Tips for the practicing M.D.
on keeping up to date*



When the experts dissect post-graduate education, they often end up shaking their heads over two disturbing findings:

¶ Medical educators are not supplying enough study opportunities.

¶ Practicing physicians are not grasping fully those that exist.

Medical educators mulled over those twin problems at a recent conference*. Out of it came some practical ideas on how doctors could keep abreast of scientific advances. But the session was tinged with criticism of both producers and consumers of p.g. education.

Says Dr. Robin Buerki: "The brutal truth is that we just aren't keeping the active practitioner up to date. Educators in medicine have recognized that fact for fifty years. Some optimists have said: 'Wait until the boys we are now training have been out ten years—then see the difference.' But today those men are further behind than physicians were fifty years ago—not because they aren't willing to keep up but because science is throwing more at them each day."

*See introductory box, page 52, this issue.

Dr. William A. O'Brien fills in the other side: "We all have to do something to keep up after we leave medical school. But today, only about 25 per cent of our doctors really attempt to continue their training. The physician who is 'too busy' to keep up finds suddenly that he is too far behind to catch up."

But what can the average M.D., whose practice today is near its peak, do about continuing his education?

One of the best ways to keep up, Doctor O'Brien thinks, is by maintaining careful case histories and records of all patients. "Then compare your results with those of other physicians," he says. Study clubs and clinical clubs offer a handy way of accomplishing this. Or simply going over interesting records with small, informal groups of M.D.'s will do the trick.

Hospitals, too, can help turn the spotlight on significant case histories, Doctor O'Brien believes. "A doctor should get more out of his hospital's educational program than from any other source," he says. But

he notes that most hospitals are missing a good bet by not organizing staff meetings with an eye toward education: "When a staff member presents an interesting case, those in charge should see that records of comparable cases are dug out of the hospital files or obtained from other sources."

Equally adaptable to the individual doctor is the reading program, Doctor O'Brien remarks, noting that "C. J. Mayo read an hour a day all his lifetime. The man was so exact that if he missed an hour one day, he would pick it up the next. Few doctors can say as much."

Then there are such devices as trips to large medical centers and brief sessions with detail men, he points out. The average practitioner can make capital of both these, in Doctor O'Brien's opinion.

He is less impressed by opportunities for learning at medical society meetings. "Today there is a tendency all over the country for medical associations to drop scientific programs in favor of those dealing with medical-economic affairs," he remarks. "Maybe it is just as well. Maybe that is the better purpose of the medical association."

From another source comes a sharp rap on medical society knuckles. Says Dr. Ozro T. Woods: "Proper recognition of the doctor's increasing ability after he gets out of medical school is important. The man's achievements in medicine ought to be recognized by the medical body to which he belongs.

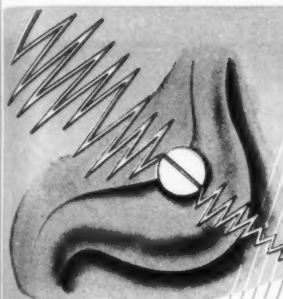
County medical societies and some groups do a poor job of this."

What about formal post-graduate courses? Evidence indicates that they need some reslanting. Says Doctor O'Brien: "Medical schools have been slow and fumbling in their approach to the problem of continuing education. Their efforts have been largely disorganized. But they can count on the eagerness of practicing physicians to come back."

Why have medical schools fumbled the ball? In most cases, he thinks, because "they didn't realize how sharp a man has to be in country practice if he's going to make decisions and live with the results."

Adds the registrar of New York's Post-graduate Medical School: "Men who come back for p.g. courses want an entirely different teaching approach from that of the undergraduate in medical school. I've heard many complain because their teachers talked down to them, or because the courses were not sufficiently practical, or because they weren't given a chance to ask questions. Post-graduate teaching cannot be done effectively by persons who spend most of their time teaching undergraduates."

Also clouding the issue are the fuzzy titles tacked onto p.g. courses. Doctor O'Brien puts on his avoid-at-all-costs list such words as conference, symposium, seminar, workshop, and institute. Typical of the confusion in p.g. education, he thinks, is the term "refresher



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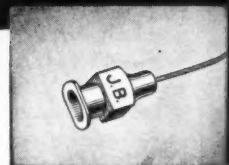
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course." "It is such a cynical term," he says. "It means you knew once, but now you've forgotten. So someone will show you a lung and say 'This is a lung.' What he should be showing you is how to treat a patient with a lung ailment."

But suppose these flaws in p.g. education can be cleared up. How can the doctor get away from his practice long enough to take a formal course?

"We've got to encourage graduates to take the bull by the horns," says Doctor O'Brien. "Patients expect them to get away at regular intervals. One doctor near us has taken every Tuesday off for twenty-three years. Each Tuesday he comes to the university and meets a regular schedule of p.g. courses. In all that time, he has missed only three or four classes."

Dr. Leslie K. Sycamore has another suggestion: "Why not have internes substitute for rural practitioners who want to take postgraduate courses? The interne could take care of the community's general medical needs until the doctor returned. And it would give the substitute a down-to-earth idea of what rural practice means."

A good example of a helpful study program for practicing M.D.'s is found at the University of Minnesota. "During ten years of operation," says Doctor O'Brien, "our p.g. school has brought 27,000 persons back for continuation studies. In the hospital and public health unit, we have given more

than 500 courses. We believe that p.g. students should live together (we have a \$400,000 building that houses eighty) and that they should pay for what they learn. Our faculty, recruited from many sources outside the university, is recommended for its service.

"So many p.g. schools first pick their teachers, then ask them what they can teach. We have no fixed schedule of courses, but plan them according to demands from the field. Last summer, when a polio epidemic started, we began a series of one-day courses on the disease almost as soon as the first case was reported. Some 500 active practitioners came to the school for those courses.

"I think this marks the start of a new type of educational organization in this country.

"We went into this business haphazardly. Now we realize it's here to stay. We have to keep medical school graduates doing the kind of practice they were taught to do during their school days."

What's the prerequisite for good post-graduate education? Doctor Buerki sums it up: "The vast majority of the medical profession must *want* to keep up. If most p.g. programs fail to meet the majority's needs, it's because the majority fails to be sufficiently vocal.

"Keeping practicing M.D.'s up to date is a challenge to the medical schools. Even more than that, it's a challenge to the doctors themselves."

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AMCP Wins New Support for Broad Prepay Program

Medical plans flock to join coordinating agency



Safely past an anemic childhood that had some onlookers reaching for black arm-bands, Associated Medical Care Plans last month appeared to have reached a lusty adolescence. Twenty-one prepay plans approved by medical societies had joined during the spring. Total membership of the AMA-sponsored coordinating agency was now thirty-nine. It included all but a handful of the major, society-approved prepay projects.

AMCP's new lease on life presaged a busy future. Chief among its new means of spurring prepay enrollment was a joint Blue Cross-AMCP committee. This body would think up ways to link medical plans more closely with their hospital counterparts.

Second on AMCP's docket was some intensified research to supply comparative figures on administrative costs and on utilization of benefits. AMA Economist Frank G. Dickinson would direct this phase.

Also due for new stress was a national advertising campaign to publicize voluntary health insurance.

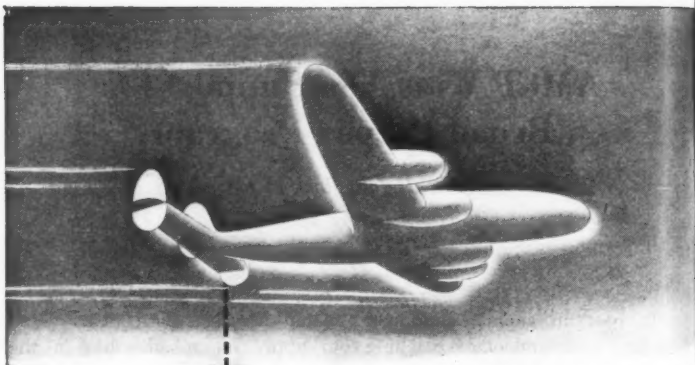
The governing body of Asso-

ciated Medical Care Plans voted to apply for membership in the U.S. Chamber of Commerce, where it saw a chance to get in some fruitful plugs for prepayment. It also authorized Dr. L. Howard Shriver of Ohio Medical Indemnity, Inc., to speak for AMCP at hearings on Senator Taft's National Health Bill, S.545. The medical care plans had never before sent an official spokesman to Washington.

Much of the credit for AMCP's recent expansion goes to its lay director, Frank E. Smith. He crisscrossed the country on a 25,000-mile trip that took him to the headquarters of fifty-six medical care plans. Everywhere he posed the same question: "Under what conditions will you join AMCP?" He collected a dossier of prepay problems, a few rebuffs, and a basketful of applications.

Asked what had held AMCP back so long, Smith pointed to two stumbling blocks that, more than any others, had retarded his agency:

1. The commercial carrier bugaboo. Many medical society plans had shied away from AMCP until



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convinced it was not out to push commercially sponsored health insurance plans.

2. The question, "Why should we join two national organizations?" Most medical plans had some tie with Blue Cross. Their officers had to be sold on AMCP's value.

Major plans still outside the fold last month included New York's, headed by United Medical Service, and the Washington State Medical Bureau. The New York plans expected to join as a group before summer. Washington had put off action until this summer.

Smith's tour yielded new figures on the current scope of voluntary health insurance. In thirty-two states, he found, fifty-five nonprofit medical care plans were in full operation. In eleven states, plans

were being readied for operation. In five states, medical societies had not passed the discussion stage.

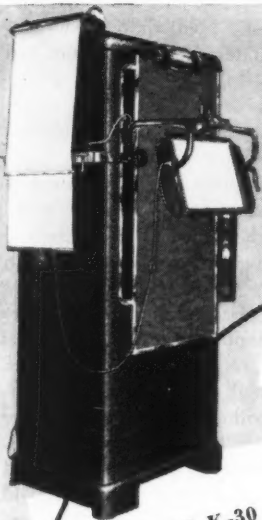
Before AMCP can claim adulthood, several problems must be thrashed out. For example, what about nonprofit plans that compete with each other in a single area? AMCP has so far given its imprimatur only to the larger plan wherever two conflict. That leaves some prepay projects out in the cold. Another poser is how to achieve reciprocity among plans.

Although these and related difficulties will not be settled easily, the outlook is far better than it was. AMCP now has the support needed to give national cohesion to prepaid medical care. Doctors can draw encouragement from its good health at this stage.

—JOHN BYRNE



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The Meaning of Social Medicine

*Family physicians must take lead in
public health, says Lord Horder**



Medical services should provide everything science can offer toward the preservation of health and the cure of disease. The whole body of knowledge must be implemented in the citizen's interest. Those benefits should be available to the entire population. No single plan can be applicable to all parts of the country. Experimentation must be encouraged.

Since the public has a vital interest in our plans, it should be adequately represented in their formation. But since physicians must render the medical care, they should play the dominant role in the preparation of the scheme they will be called upon to carry out.

What should we think of an airplane designer who proceeded to the point of manufacture and then and only then asked the pilot to take the machine into the air? This is what has been happening in Britain. Parliament has put a comprehensive law on the statute book without discussions with the medical men and women who have to implement it. Such meetings as did take place between the Minister of

Health and representative groups of the profession were spent in the former's announcing an *ipse dixit* and giving the latter no chance to reply.

The belief has been expressed that gradual extension and improvement of medical care is preferable to revolutionary change. It is also held that, while we recognize government responsibility for the citizen's health, sweeping legislative action would defeat its own purpose by impairing the spirit and quality of a service that is essentially individual and personal. This estimate marches with the view we physicians have taken in the United Kingdom, *vis-a-vis* the Socialist intention of nationalizing our medical health services and of making the doctor a civil servant.

We had hoped that, through the natural process of evolution, rather than through the method of revolution now being adopted, the government would help us attain our object. We think we could have set up health centers without sacrificing the doctor's liberty and we could have brought together in a comprehensive whole the industrial

*See introductory box, page 52, this issue.

[PLEASE TURN TO PAGE 131]



ANTON VAN LEEUWENHOEK
(1632-1723). Invented the microscope. With an unexplored natural world before him, all of his observations of bacteria, protozoa, hydra and of his observations of bacteria, protozoa, hydra and many other organisms were discoveries of startling importance.

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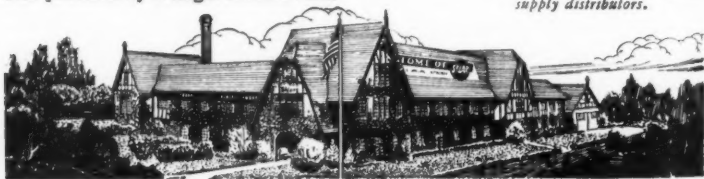
It is a special alloy of this world's finest stainless steel—*American made* stainless steel—that gives to Sklar instruments their incomparable quality—that has made the name Sklar on a stainless steel surgical instrument a guarantee of complete dependability under all conditions.

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medical services of the various government departments.

We realize that this less dramatic method of advance is not adapted to our present Government's temperament. But we know from experience that such an advance is eminently suited to the progress of medicine and to the citizen's health and happiness.

You cannot stereotype medicine without great sacrifice. It is easy to level down, difficult to level up.

The nature of the anxiety facing our profession today in Britain is that it lies in a realization of the tremendous centralization of power the new health act invests in the Minister of Health. The elder Pitt said, "Unlimited power is apt to corrupt the minds of those who possess it." Acton went further, saying, "All power tends to corrupt and absolute power corrupts absolutely."

The ideal to be aimed at in framing a medical service policy for the nation is not this terrific centralization of power in one man but a maximum of central direction and a minimum of central control.

The quality of medical care must

be preserved; provision of public health services is essential; there must be effective use of hospitals with adequate facilities; trained professional and non-professional personnel is a *sine qua non*; optional results require organization and coordination of physicians as by an extension of medical groups and through health centers; voluntary prepay plans are needed; extensive education for physicians and the public is required; the local needs of the community must be allowed for; and, finally, Government help, preferably by grants in aid, will be necessary.

Some units of our health services stand out as pieces of perfect organization and efficiency—e.g., the large teaching hospital, some of our public health services, our medical research councils, and your equivalents of these. But when we consider the machine as a whole, organization and efficiency are found to be unsatisfactory.

We cannot scrap our health services and start from scratch, however, unless "bloody revolution" should give us an opportunity. In

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our countries, thank God, it is unlikely to do so. Starting from scratch would entail chaos and enormous expense.

In Russia there has been such a chance, and it has been taken. Soviet health services, the physicians included, have been worked out with thoroughness on a communal plan. This plan eliminates the notion of the family unit, to which we attach such great importance; it disallows a free choice of doctor for the citizen; and it also makes continuity of care impossible.

How can *we* tighten up our health services? Whose job is it?

Probably everyone's.

Into this effort to clarify, simplify, integrate, and reorient come the

common man, the sociologist, the economist, the statesman, the borough councilor, the researcher, the health officer, the family doctor. How can the efforts of all these be coordinated? Do we need a small group of knowledgeable and wise persons, with a roving commission, carrying so much personal prestige that their influence in surveying, advising, and adjusting would almost amount to power to act? Could we in some such way encourage a more extensive trial of regionalized coordination?

This seems worth considering. Regional coordination of the work of hospitals is a principle almost, if not quite, conceded; to extend the principle to personnel should not be



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impracticable. For us physicians the stage is clearly set. The citizen is raw, but he is amenable. He is more health-conscious than he has ever been. He is more aware of the value of health. He is more willing than he ever was to be taught how to be healthy.

Although we have not been blind to medicine's sociological aspects, we have done little about them. Recognition of the omission has gone far in the United Kingdom toward deciding our statesmen that something should be done about it. Looking at our health services in a more objective way than the physician can possibly do, our statesmen take note of this big gap that the doctor is doing so little to fill.

To make medicine a complete science in the service of man we must arrange that it infiltrate this important, and now more clearly perceived, sphere of social need. This sphere lies between that in which the diseases of the individual

patient are treated by the individual doctor and the zone in which the public health is preserved by the state health officer. This largely untilled field includes all the environmental factors that influence the citizen's health and happiness: his conditions of work, his home life, his sense of security or insecurity, and his ignorance of the things that make for the salvation of his body and his mind. In short, as Professor Ryle has it, "Our next advance [in medicine] will be . . . concerned with the ultimate, rather than with the intimate, causes of disease."

I do not feel at all hopeful that the physician is capable of dealing with this aspect of medicine. I believe his incapacity to be due to two things: his lack of training for the job and his lack of time in which to do it.

The student's pre-medical education is lopsided. Almost from the moment he decides to become a

Ice Breaker

A young woman doctor in my husband's office was eager to ingratiate herself with her colleagues. One morning she came across a reprint on a pet subject of one of her male confrères. In a fever to please, she phoned to say she was sending him an article that was right up his alley.

Next morning the article came back with a note saying, "I didn't know you cared!" She had sent him, not the intended material, but another reprint, entitled, "Use of Androgen in Cases of Impotence."

—DOCTOR'S WIFE, TEXAS

COMPARE THIS INFANT CEREAL WITH ANY OTHER!

For ingredients... Clapp's Instant Cereal is made from the following ingredients: whole wheat meal, corn meal, wheat germ, malt, nonfat dry milk solids, calcium phosphate, dried brewers' yeast, salt, and iron ammonium citrate.

For nutritional values... 1 oz. serving of Clapp's Instant Cereal furnishes the following percentages of the minimum daily requirements:

For infants, vitamin B₁—120%, vitamin B₂—20%.

For young children, vitamin B₁—60%.



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PRODUCTS OF AMERICAN HOME FOODS

Iron—113%, Calcium—32%, Phosphorus—22%.

(The essential Calcium, Phosphorus, and Iron requirements of infants, and the vitamin B₂ requirements of children have not been established.)

Typical Analysis of Clapp's Instant Cereal

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|------------------------------------|----------------------------------|
| Carbohydrate 73.1% | Iron (Fe) 30 mg. |
| Protein (Nx6.25) 15.0% | per 100 gm. |
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| Crude Fiber 1.6% | Thiamine (B ₁) 1.0 |
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| | Moisture 5.7% |
| | Calories per ounce 102. |

For taste... When mothers report a "Cereal Problem," suggest a change to Clapp's. Infant cereals vary widely in flavor. The sweet, nutty flavor of Clapp's is one most babies love.

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The Council on Foods of the A.M.A. suggests that infants' cereals may well be selected upon the basis of furnishing vitamin B₁ and Iron. Both Clapp's Instant Cereal and Clapp's Instant Oatmeal are excellent sources of these two food elements.

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doctor, his interests tend to be more and more narrowed. Medicine, which should have the widest contacts of any profession, almost ceases to be a "liberal" education, for its cultural outlook dwindles from this moment.

In a memorandum on medical education, a medical students' association says: "Many sociological problems have a bearing on the health of the patient, *e.g.*, unemployment, hygiene. At present only the purely medical aspects of these problems are touched on by the medical student. We feel, however, that a purely medical approach . . . [is] incomplete. It is only by seeing such cases as a part of the social phenomenon, in addition to seeing them as individual patients, that a full view can be obtained. In teaching diseases, sociological weapons such as education and legislation are assuming greater importance than hitherto. We therefore recommend that sociology should be included as a subject in the official syllabus."

This is a modest beginning, but it is a beginning. The association considers that our technology has outrun our sociology, a conclusion to which I heartily subscribe.

During the clinical period of his training, the doctor should be made familiar with the application of medicine to groups as well as to individuals, to the principles of industrial medicine, to rehabilitation, to family planning and the practice of contraception, to nutrition, to the

hygiene of the home, to environmental factors in the etiology of disease, and to the cause and the prevention of the anxieties of life. I assume that neo-natal and maternal welfare and the needs of the school child are already dealt with by others.

Personnel fitted to lecture to the student on these sociological matters is at present inadequate. There are at the moment only two chairs in social medicine in Britain; there should be at least a dozen. This difficulty will not be overcome until the importance of the matter is recognized by those who have statutory power in the arrangement of the student's training.

The doctor's work in the future will be more and more educational, less and less curative. More and more will he deal with the physiology and psychology of his patient, less and less with his pathology. He will spend his time keeping the fit fit rather than trying to make the unfit fit. We must make it worth his while to do this. This reorientation of his education and of his work is long overdue.

The other handicap to the physician who would further "social trends" in medicine is lack of time. This, as I say, is probably a more severe handicap than mere lack of special preparation. After all, the doctor is in the very midst of the social fabric. He sees the people's needs, and his natural inclination is toward helping. But time is essential, and this he just hasn't got. He

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hasn't got it because he is generally grossly overworked and his day is badly organized. It is here, perhaps more than anywhere else, that the need for developing our health services is so urgent.

When the statesman seeks to free the doctor from trivialities and time waste so that he may be able to pull his weight in the field of social medicine, he deserves and must get all our sympathy and help. But many of us in Britain think this freedom should not be obtained by nationalizing medicine, because such a policy would lose to medicine two of its most virile characteristics: its individual initiative and spirit of adventure.

How, then, are we to free the doctor from his grind and hurry? I think the health center is the answer. The health center could do much to organize a doctor's work; it could also save him from the sterilizing effects of isolation. Moreover, it could be a place where the social aspects of medicine might be studied.

The state health officer's job is better defined than is that of the physician; and he has the power of the state behind him. For these reasons his results are seen more quickly and more easily. The physician is up against the lag inherent in the individual; progress is there-

fore slower and less apparent. True, when the state imposes compulsion on the individual, progress, even in the doctor's sphere, seems to be more rapid. But the sacrifice of personal freedom is too big a price.

Today we do not wait for authority; we initiate and we plan and we work out our salvation. But the physician is so inactive in these efforts. He should be playing a leading role; actually, it is difficult to recruit him for the councils of the voluntary organizations that are attempting something in the sphere of social medicine. The members of the state medical services plead they are not free agents; the general practitioners plead their already overcrowded life.

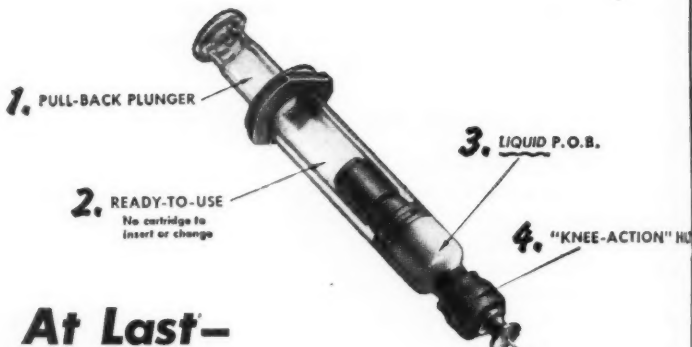
When I consider a few of the social movements (as they are hopefully called) in which I am interested (eugenics, family relations, marriage guidance, Peckham Health Center, food education, noise abatement, national parks, cremation) I remember how few of my colleagues I meet in the committee rooms of these groups; the reasons given are usually those I have mentioned. Our representative medical bodies are nearly as detached from things like these as are the individual members of the profession. They are busy with their domestic politics, with academic matters, and

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2. **READY-TO-USE** Cutter's Penicillin Oil-and-Wax syringe is ready to use "as is!"
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4. **"KNEE-ACTION" HILT** . acts as shock absorber. The needle is mounted in rubber, allowing "play" without danger of snapping needle. After using, toss the entire syringe away.

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It is much the same with some more intimate and pragmatic matters, which touch the common health closely. Some of us have recently been fighting the battle for bread, pleading that there should be a specification of the national loaf in respect of certain token nutrients. Our backing by physicians was scanty. Then there was, and still is, the effort to clean up the milk situation. The contribution made by doctors in my country to get compulsory pasteurization for all pooled milk has been meager. If I named yet a third matter of importance to the public it would be quack medicines. We were able only recently in Britain to establish the principle of "disclosure" in respect to these; meanwhile, the intimidating character of the advertisement still goes on unchecked. Who can doubt that concerted opinion expressed on the part of the doctors would force action in the public interest?

The physician owes his power to three things: to his training, to his humanist outlook, and to his opportunity to effect a "close-up" with the individual patient. We must insist that the "close-up" be preserved in any attempt to integrate our health services; it is a privilege that should be guarded jealously in the interest of the citizen and of medical progress.

Equally important, I want to see a "close-up"—or, more accurately, a

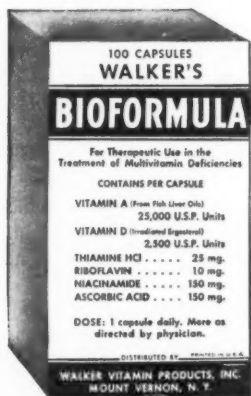
"closer-up"—between the physician and the social services. Is the family physician going to continue only to cure or relieve disease? Or is he going to make contact with this public health business, which we are finding to be so vital a national asset? This rigid distinction between the family physician and the state health officer, and the antipathy so often seen between them, are surely due to a misconception on both sides of what the medicine man's function really is.

We all pay lip service to the importance of preventive medicine. But again and again we say, "That is the health officer's job," when really it is every doctor's job. To do the G.P. justice, he makes many contributions to preventive medicine that are not recognized as such. But they should be recognized and it is the business of the state to recognize them. Inevitably, if the G.P. does not accept the challenge of his position, the state health service will expand while that of the G.P. contracts. Then the rivalry between private and public medicine, which we all deplore, will be intensified.

I want to see the physician not only use the public health services, not only edit them, but also show some passionate conviction about them in his patient's interest. Take school meals as an example: If the physician is only doctrinaire on the matter, and not intensely practical, Mrs. Jones isn't stimulated; the local education authority doesn't get busy.

[PLEASE TURN TO PAGE 143]

WALKER



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Take the case of industry: Work is good; work is health-giving. But it is the doctor's duty to protect the worker against excess fatigue, against dullness, and against the various hazards of his job. In all these matters medicine has accumulated a mass of facts, but they are largely wasted because they are not implemented in terms of social service.

If I embarked on the subject of nutrition I could give equally striking examples of the need for the physician's direction and execution. To say the truth, there is little in the life of John Citizen, whether he be in a factory, an office, or a public utility service, that does not give

the physician scope for the practice of social medicine. Consider the basic needs of the citizen:

- ¶ Sufficient of the proper food.
- ¶ Suitable shelter and clothing.
- ¶ A satisfactory job of work.
- ¶ Access to the fresh air and sun.
- ¶ Reasonable leisure and the amenities of life.

In every one of these the doctor must stake out his claim, for in every one of them his knowledge can guide and his enthusiasm can stimulate to achievement. It is not as mere passengers that we physicians must take part in these affairs. We must lead. We must guide the politicians, since they cannot act effectively without expert help. And we



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You will like the dependable antipruritic action of Hydrosal Ointment which is accomplished without the use of anesthetic drugs.

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must keep the citizen's end up since he learns to rely on us for this.

But suppose the politician won't be guided? Suppose it is as Swift wrote in a letter to Pope: "Although I have known many great ministers ready enough to hear opinions, yet I have hardly seen one that would ever descend to take advice; and this pedantry ariseth from a maxim which they themselves do not believe at the same time they practice it, that there is something profound in politicks which men of plain honest sense cannot arrive to."

In that case the physician has no alternative but to appeal to public opinion; he must continue to serve his patient in the manner that he believes to be in the patient's best interest.

If anyone should ask me, point-blank, "Do you see hope in the future of medicine?" I should reply: "Yes; I see more hope, for ourselves as doctors and for the people who will come under our care, in the future of medicine than perhaps in any other single thing in the new world toward which we are hacking our way. We at least have not—yet—forfeited the trust of people for whom we work. We at least have not—yet—turned inward in despair, bartering our spirit of adventure for a mere hope of security. We stand for sane knowledge, selflessness, and mercy in a world gone mad. We cannot let these people down who trust our profession. It is in this firm resolve that we shall face the future of medicine."

—LORD HORDER

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Dexedrine therapy not only alleviates the mental depression and psychogenic fatigue which ordinarily accompany dysmenorrhea; but also, through its marked amelioration of mood, beneficially alters the patient's reaction to pain.

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Dexedrine Sulfate tablets

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New

*crystalline penicillin G in a
100,000 unit segmented tablet*



Here is new convenience and economy in oral penicillin therapy. Bristol has provided a 100,000 unit *segmented* tablet, formulated of Crystalline Sodium Penicillin G, and adequately buffered against gastric acidity. Extra potency is available where required, yet the scoring permits easy separation for lighter dosage. Available in bottles of twelve tablets from your usual source of supply.

The penicillin contained in the new Bristol 100,000 unit tablet fully meets official specifications for Crystalline Sodium Penicillin G. Therapeutically, this form of the antibiotic is highly effective. Inert materials have been virtually eliminated. No refrigeration is required.



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LABORATORIES INC. SYRACUSE, NEW YORK

The Newsvane

Sees Increased Demand For X-Ray Services

It will be a year before the supply of medical X-ray film begins to catch up with demand, says the American College of Radiology; and it will be several years before the physician can get all the film he wants. Production is at an all-time high and film exports are no greater than before the war, says the college, but greatly increased demand for radiological services has created a shortage.

The ACR points out that many patients are now able to pay for X-rays who could not afford them before and that physicians are adding to their armamentaria. It cites a MEDICAL ECONOMICS sampling (January 1947) which indicated that 35 per cent of doctors intended to buy X-ray units within a year.

On-the-Job Training for Medical Secretaries

Hartford (Conn.) Hospital is one of the few in the country that gives a post-graduate training course for medical secretaries. So successful was the course initiated last year

that another will be given this year (in July). The program aims to give on-the-job training to junior-college graduates of medical secretarial courses. Last year's class of three girls worked in the tumor clinic, the urological clinic, on the operating floor, in the laboratory and administrative offices. Within five months the girls could substitute for any secretary in the hospital. At graduation the hospital snapped up two of the students itself.

Babies to Stay With Mothers

Several hospitals have inaugurated a procedure they call "rooming-in." A newborn baby is no longer whisked away to the nursery, but is left in a crib beside his mother's bed.

Behind this relaxed attitude is the belief that the psychological effects of separation are worse than any risk of infection. Separation, it is pointed out, also denies the new mother a chance to learn baby handling through observation of the hospital nurse's methods.

[PLEASE TURN TO PAGE 148]

The trouble with rooming-in for the general hospital is said to be the cost of conversion, most such institutions being built to operate with a nursery. George Washington Hospital in Washington, D.C. is the only building specially designed for rooming-in.

At Grace-New Haven (Conn.) Community Hospital, which is one of several institutions experimenting with the procedure, each new mother's over-the-bed table is equipped with a special container for the baby's needs: diapers, oil, pledgets, etc.

'What G.P.'s Should Know About Sister Kenny'

An editorial in the New York State Journal of Medicine suggests that the general practitioner get a clear idea of what the Kenny treatment is and isn't.

"Anterior poliomyelitis is one of the most mysterious diseases in the world," the Journal reminds. "Patients initially paralyzed from the neck down may recover completely; cases afflicted with paralysis of but a single muscle may make no improvement whatever."

Sister Kenny's method may be helpful, says the Journal, as long as it's not given until the first stage of the disease subsides; but is no more

certain as a cure than forms of treatment that have long been advocated by orthopedic surgeons.

"We object passionately to the impression given . . . that if you have a child stricken with the dread disease and do not furnish him with the Kenny treatment you are condemning him to a lifetime as a cripple."

Post-War Boom In Birth Rate

The U.S. birth rate is booming. After a steady decline from 1915 to 1933, the rate jumped from 17.1 births per thousand in 1937 to 28.8 per thousand in 1946.

During World War I the rate dropped, rising slightly only after the armistice. All during World War II, however, the rate climbed steadily.

Mothers, Not Doctors, Sign Certificate

Responsibility for signing birth certificates has been transferred from attending physicians to mothers in a procedure being tested in ten Louisiana parishes. The doctor is now required merely to report the birth to the local health unit within forty-eight hours. As in the past, hospitals prepare the certifi-

EMPLOYING A CEREBRAL SEDATIVE?

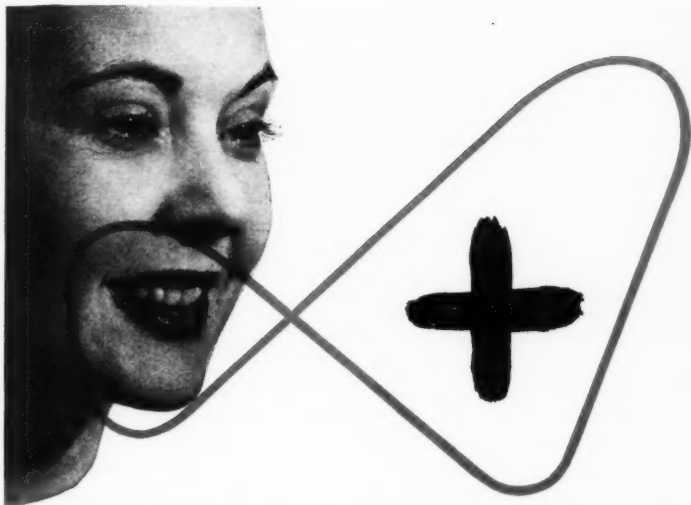
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Valuable in Parkinsonism, delirium tremens, narcotic addiction, preanesthetic medication and as an amnesic in labor.

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"Premarin" provides naturally occurring conjugated estrogens for effective therapy by the oral route with comparative freedom from untoward side effects.

"Premarin" is available as follows:

Tablets of 2.5 mg. bottles of 20 and 100.
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Tablets of 0.625 mg. bottles of 100 and 1000.
Liquid, containing 0.625 mg. in each 4 cc. (1 teaspoonful) bottles of 120 cc.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present as water-soluble sulfates. The water solubility of conjugated estrogens (equine) assures rapid absorption from the gastrointestinal tract.



CONJUGATED ESTROGENS
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"Premarin"

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cates and see that mothers review them before signing.

The system was devised jointly by the Louisiana Department of Health and the U.S. Bureau of the Census. If it works, the legislature will be asked to make it mandatory throughout the state.

Chiropractic's Case Is Challenged

"Chiropractic Presents Its Case," an article in the February Reader's Digest, has been answered by Dr. James A. Gannon of Washington, D.C. In a letter published in the Medical Annals of the District of Columbia, Doctor Gannon says it isn't true that the medical profession persecutes chiropractic; physicians simply ask that a practitioner

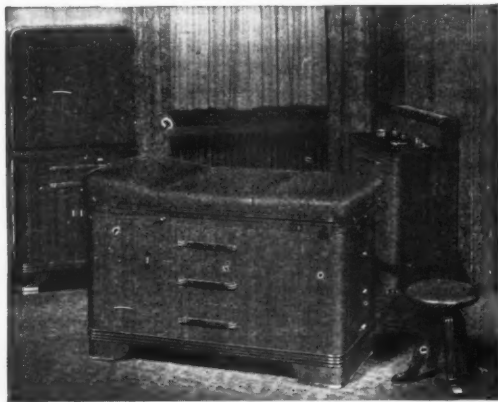
prove his ability to understand the disease he is treating.

Since February 1929, according to Doctor Gannon, the District of Columbia has required applicants for licenses in the healing arts to pass examinations in the basic sciences as well as in their particular fields of practice. Since that time no chiropractor or naturopath has been granted a license there, he reports.

Sleeping-Pill Habit Alarms Doctors

Medical societies have begun to propose legislation to restrict the sale of barbiturates. Many doctors find them as habit-forming as narcotics. "They produce dependence indistinguishable in many respects

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from dependence on morphine and opiates," asserts Dr. Harry Gold of Cornell Medical Center. Under the suggested amendments, prescriptions could be refilled only when there is a specific order from the physician.

Mississippi Acts To Get More Doctors

In 1941 the Public Health Service cited Mississippi's ratio of active physicians to population as the lowest of any state (1:1,700). In 1946 the state legislature took corrective steps. It authorized the Mississippi State Medical Board to grant scholarship loans to students who signed contracts to practice in rural Mississippi.

So far the board has awarded forty-seven loans. Students are attending eleven different medical schools throughout the country, although the majority are in Mississippi's two medical schools. They include twenty-one World War II veterans, six women, four Negroes.

A Doctor's Life In the USSR

Dr. Andrei Likachev, director of the Moscow Medical Institute, has told the foreign press that all the 150,000 doctors of medicine in the Soviet Union are members of the Trade Union of Medical Workers. The Government pays them from \$270 to \$360 a month, two or three times the wage of an ordinary

worker, he says. To increase their incomes, they can practice privately after hours, he says. Doctors who become professors of medicine, get about \$1,000 a month, he says.

The Russian medical student begins a six-year course after high-school. He (or she; 50 per cent of Russian doctors are women) starts work with patients in the third year. The Ministry of Medical Industry assigns him to a vacant practice at graduation. Beginners usually serve first in a rural location.

Baby Survives Red-Tape Diet

Life under the Labour Government was described recently for members of the British Medical Association by Dr. R. L. Gibson of Buskington, Lincolnshire:

Mrs. S., a new mother and a patient of Dr. Gibson, needed a thermos to keep milk warm for her baby. The doctor filed a certificate with the Board of Trade asking that she be allowed to buy one. The Board replied that the certificate failed to specify the reason for the request, which it therefore denied.

Dr. Gibson wrote on a second certificate that his patient was a nursing mother. The board again found the certificate inadequate; it didn't say *why* she needed a thermos.

In his third certificate the physician amplified his statement that the patient was a nursing mother. He said she needed the flask to feed

the baby at night. The board replied that the certificate was still inadequate; it didn't say whether she already had means of heating the milk.

In his fourth certificate Dr. Gibson added that the patient had no cooking facilities. The board granted the request.

But time had passed. When the overjoyed physician told his patient the good news, she had already got a flask from a farm-hand.

Surgeons To Change Hospital Rating Plan

After following the system since 1918 of grading hospitals as fully or provisionally approved, the American College of Surgeons expects to institute a point-rating plan. The proposed change would give recognition to hospitals which more than meet standards as well as to yearly advances—or declines. For the present, however, the old system is being retained. Increased costs and personnel shortages make it hard right now for even the best hospitals to do more than meet basic standards, says the ACS.

G.P. Plays Role in Cancer Campaign

"General practitioners have the greatest opportunity for discovering early cancer because they see more patients than all the hospital clinics combined." So said the New Jersey Medical Society in opening a state-wide tissue diagnostic service for family physicians. Under the new arrangement, the G.P. performs the biopsy and sends the tissue to a private pathologist for processing and diagnosis. The pathologist charges his regular fee (except in the case of an indigent).

The project has been sponsored by the medical society, the New Jersey Society of Clinical Pathologists, and the American Cancer Society. The latter group distributes free specimen containers and fixative to all physicians who ask for them. In submitting a specimen for analysis, the doctor sends a brief form giving pertinent facts about the patient. The pathologist writes his diagnosis on the form and returns it. The G.P. makes it part of the permanent record.

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Cultists Denied Bid For Free Rein

An attempt to emasculate Ohio's medical practice act was defeated recently when Attorney General Hugh S. Jenkins rejected a cultists' petition. The petition called for repeal of the section of the law that limits licensure to accredited physicians and surgeons. It asserted that



**"IT'S MRS. DENNY —
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**DOCTOR, has this ever
happened to you?**

Here's a suggestion, Doctor—treat emergency dental pain with the well-known **POLORIS DENTAL POULTICE**—provides prompt, safe relief until more complete dental treatment is available—usually eases pain without need for opiates or sedatives—will not interfere with subsequent dental treatment. For over 30 years the dental profession has prescribed **POLORIS** for pain caused by:

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the act gave monopolistic status to medicine and surgery, "which comprise only a very limited part of the whole field of health." It also stated that since cultists did not practice medicine or surgery, they should be allowed to carry on without the formality of licensure.

The Attorney General rejected the petition on the ground that it was not "a fair and truthful summary" of the proposed amendment, as required by law.

Surgeon Urges Better Medical Records

"Whatever improves his medical records enhances the self-education of the practicing physician," Dr. John Orndorff of Chicago told members of the American College of Surgeons. Yet, he added, "the average practicing physician keeps in his office medical records that he would unreservedly call incomplete and unscientific in his hospital."

Greatest single factor in self-education, argued Doctor Orndorff, is the individual patient. "As an individual the patient likely has a perplexing series of symptoms in

For
head colds, nasal
crusts and dry-
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his history, a physical examination with definite pathological findings, and laboratory work with reports of abnormal values. If the physician can piece this puzzle together in proper pattern he will advance instantly and definitely in self-education. Complete medical records . . . will increase the percentage of cases in which he will be able to formulate the correct diagnosis."

The Chicago surgeon said that from a study of the records of patients the physician can "learn the effectiveness of his treatments, make desirable changes in his methods, and improve his ability to make accurate prognoses."

But how does a practicing physician make his office records complete and scientific, Doctor Orndorff offered two suggestions. First, he said, organized medicine could help by studying the main types of medical practice and by proposing preferred medical record techniques and actual forms suitable for use in each type. Admitting that this smacked of regimentation, the doctor added that "if it could be demonstrated to the practicing physician that changes in his medical records would increase his efficiency and accuracy in his professional work, he would accept them."

Second suggestion was to introduce the Standard Nomenclature of Disease and Operations into larger offices and into group practice. This, said Doctor Orndorff, might seem to clash with his earlier statement that practicality must be the working physician's yardstick

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COMBAT DENTAL CARIES IN CHILDREN

CHILDREN'S TEETH SHOULD BE
EXAMINED PERIODICALLY



An Inadequate Supply of minerals, particularly of calcium and phosphorus, has been recognized for some years as an underlying factor in faulty skeletal growth and in improper tooth development and enamelization. More recently the importance of a minimal but adequate intake of fluoride has been emphasized as a factor in decreasing the incidence of dental caries.

Not only during growth but during pregnancy also there is an increased need for minerals since decalcification, which is frequently accompanied by dental caries, is common.

Fluorossteel Armour is a logical means of overcoming mineral deficits because Fluorossteel Armour, which is prepared from femurs of government inspected cattle, contains about 95 per cent calcium and phosphorus with smaller percentages of magnesium, sodium, potassium, strontium, barium, silicon, aluminum, iron and traces of chromium, copper and manganese. More important, Fluorossteel Armour contains small amounts

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Fluorossteel Armour is available in two forms:

1. 5 grain tablets (bottles of 100, 500 and 1000).
2. 5 grain telescopic gelatin capsules (bottles of 100, 500 and 1000). The powder may be readily removed from these capsules for incorporation in formulae or semi-solid food.

The dose for children up to 3 years of age: 10 grains daily in food or liquids; children 4 to 8: 15 grains daily given as above. For older children and pregnant women, the tablets may be prescribed to be chewed and swallowed (3 to 6 daily).

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HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN

in determining the type and scope of his records. But to demonstrate that what he recommended was feasible, the doctor cited the fact that physicians in his own office were using the Standard Nomenclature with encouraging results.

After much debate, he said, he and his two colleagues had devised and set up this system. A part-time record librarian codes their diagnoses and then types visible index cards for both diagnosis and operation files. She then adds a summary sheet to each one. Arranged in parallel columns, these summaries list final diagnoses and, opposite them, all services rendered, including operations and outstanding non-surgical procedures. "We hesitate to call the plan a success," said Doctor

Orndorff, "but I believe we can see signs to dispel our pessimism. If successful, I believe we will have done something for the self education of our group. The study of our groups of cases will be greatly facilitated by this ingenious system."

Says War on Disease Is No Private Affair

Something better than "tin-cup science" has been demanded by Perry Githens, editor of Popular Science Monthly. He uses the term to describe the work carried on by the national foundations fighting such diseases as poliomyelitis, tuberculosis, and cancer. "Every year," he says, "more millions come out of the big tin cup. But not



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WHEN frequent aberrations of the menses suggest that normal function has overstepped the bounds of physiologic limits—the physician is often confronted with a condition which proves highly distressing to the patient.

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mark, "MHS" visible
when capsule is cut
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Special Unit packages containing 5 in., 6 in. and 8 in. WIDE-WIDTH Cotton ACE BANDAGES are being distributed. Your dealer has them or can get them promptly.



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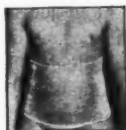


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For Postnatal Breast support the 8" Cotton ACE is recommended to insure complete support and comfort to patient. For drying up Lactating Breasts either the 6" or 8" Cotton ACE is used, depending on the height or size of the patient.

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For Abdominal Support in coughing and vomiting the 5", 6" or 8" Cotton ACE, depending again on the height and size of patient, are used with considerable success. For Post Operative Support of lower, middle and upper abdominal incisions the 8" Cotton ACE is very effective.



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For Muscular or Circulatory Support of upper thigh, the 5" Cotton ACE is used for regular size patients, or the 6" for taller or larger patients. For pulled muscles of groin of those who are muscularly heavy the 5" Cotton ACE has been found most desirable.

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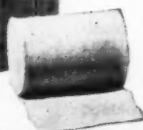
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enough. Last year 500,000 Americans had tuberculosis, 720,000 had cancer, and new infantile paralysis cases reached a peak of more than 25,000. Apparently, public health is too big for private charity.

"This is not a plug for socialized medicine. But it is a plea for peacetime Congressional action as big and bold as wartime Government action. It has been said that, handled in the wartime way, tuberculosis could be wiped out in mere years. But until Congress, which represents *you*, reaches into your pocket for the cost of the cure, you had better keep reaching yourself—and reach deep. Tin-cup science isn't too good, but it's all you've got."

M.D.'s Urged to Answer Survey Inquiries

The doctor who discards questionnaires may be hurting himself more than he hurts the statistician, warns the New Jersey Medical Society. "Analysts will interpret the replies whether your return is there or not," it points out. "If too many physicians fail to send in the ques-

tionnaire, the results will be skewed. If the questionnaire results in action, the action will obviously not be in the direction desired by the unresponsive group.

"We are entering an era of vast potential change in medical practice. We have a chance to express our opinions and record our experiences through the questionnaires that have been and will be sent out. There is no other way of polling an entire professional community. The alert practitioner will not deliberately disfranchise himself."

New Journals See Plenty Of Room at the Top

Now circulating among physicians are two big, new, and handsomely printed journals: Postgraduate Medicine, organ of the Interstate Postgraduate Medical Association, and Annals of Western Medicine and Surgery, a publication of the Los Angeles County Medical Association. Editor in chief of Postgraduate Medicine is Dr. Charles W. Mayo, Rochester, Minn. Emphasis of the new journal is on treatment; its editorial approach is

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SULFA SOLVEX relieves intense itching; destroys the fungi on contact; helps prevent reinfection. 50¢ at all Drug stores. By prescription only in states requiring it. A product of The Scholl Mfg. Co., Inc., Chicago.



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In convalescence . . .

Physicians the world over rely on this easily tolerated, outstandingly palatable tonic to restore appetite, vigor and general tone . . .

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the formula of
Eskay's famous
Neuro Phosphates,
plus appetite-restoring
Vitamin B₁

Smith, Kline & French Laboratories, Philadelphia, Pa.

informal. Contributors, says the IPMA, will discuss medicine as found in actual practice, rather than "on dress parade." Doctor Mayo concedes that there may already be too many journals but says "there are not too many in the top bracket."

Sponsors of the *Annals of Western Medicine and Surgery* aim to neutralize the "feeling of isolation among physicians on the West Coast." This feeling, they say, is caused by the "concentration of medical teaching in the East" and the fact that "medical journals are the creatures of the areas in which they are published." Now, say the *Annals'* editors, Californians who are doing important work in the basic sciences and clinical medicine

will have a chance to present their findings to West Coast colleagues.

PHS Seen Putting Over Federalized Medicine

The U.S. Public Health Service is grooming the Hill-Burton hospital construction act as a Trojan horse in its strategy to establish a system of state medicine, warns the American College of Radiology. It quotes Dr. Vane M. Hoge (who administers the act for the PHS) as saying: "The act itself is testimony to the fact that the current conception of public health includes responsibility for the treatment and care of the individual."

This was certainly not the intent

soothing...



"Behold the Sea...

Purger of earth, and medicine of men...
Washing out harms and grief from memory..."

—Emerson

Medicine's conquest of pain is as constant
as the sea.

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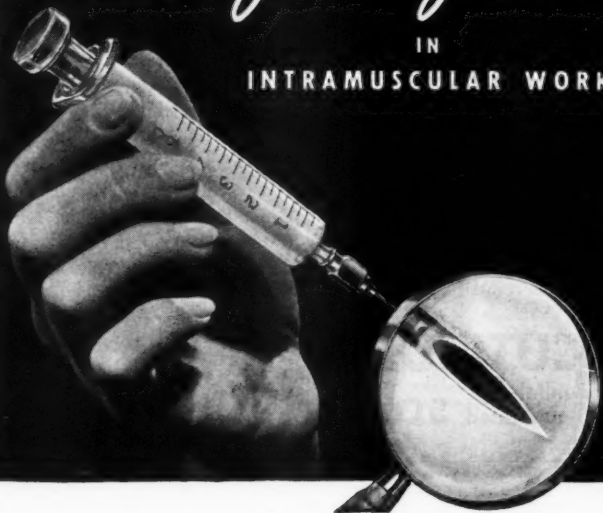
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of Congress in enacting the bill, asserts the college. Nor does it jibe with the AMA's declaration that diagnosis, treatment, and medical care of the individual are the function not of the health center but of the medical practitioner.

"It would be unfortunate, indeed," says the ACR, "if Doctor Hoge's philosophy were to prevail. His concepts are as alien as those expressed in the Wagner-Murray-Dingell Bill. Fortunately, administrative policies under the act will be determined on the state level. It is the responsibility of state medical societies to see that the Hill-Burton Act does not become a Trojan horse."

Aiding M.D.-Veterans Called Tough Job

One of the county's most active veterans' service bureaus, that of the New York County Medical Society, reports that a year's operation has produced achievement and frustration in about equal parts. In that time, the bureau interviewed nearly 1,400 M.D.-veterans, many of whom found war conditions more bearable than those of peace. One commented: "Two Jima was easier than New York." Another pointed to his discharge button and said bitterly: "This means 'Hello, sucker!'"

Despite high rents and uncooperative landlords, the bureau has managed to find office space for many veterans. All the city's reputable real estate men notify the bu-

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Relief*

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The tormenting itch of Rhus dermatitis has few equals in routine medical practice. Many patients receive early, welcome relief after injections of POISON IVY EXTRACT Arlington.

POISON IVY EXTRACT Arlington is an absolute alcohol extract of Rhus leaves of established potency. The use of absolute alcohol results in an extract of greater dependability. Use as supplied for diagnostic patch test and for treatment of poison ivy dermatitis.

Clinical evidence indicates that a single excitant is responsible for dermatitis due to poison ivy, poison oak, and poison sumac. Thus, this extract is equally applicable to dermatitis caused by contact with any of these plants.

DOSAGE: As soon as possible after appearance of symptoms, three subcutaneous injections of 0.1 cc. each are given at daily intervals.

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Arlington

SUPPLIED in rubber-stoppered
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Bowel Hygiene in Pregnancy

Constipation in pregnancy presents an important problem—it is usually necessary to prescribe some form of medication to maintain the patient's sense of well-being and to prevent or minimize the occurrence of hemorrhoids.

Since many women suffer from bowel irregularity previous to pregnancy, it is understandable that, with the added anatomical and physiological handicaps, constipation may not respond to general measures. Kondremul with Cascara enables your patient to go through pregnancy without the discomfort of constipation.

Three types of KONDERMUL:

KONDERMUL Plain

KONDERMUL with non-bitter Extract of Cascara*

KONDERMUL with Phenolphthalein* (2.2 grs. phenolphthalein per tablespoonful).

**Caution: Use only as directed.*

Canadian Producers:
Charles E. Frosst & Co., Box 247, Montreal

THE E. L. PATCH COMPANY
BOSTON MASS.

reau instantly of desirable space. (A woman broker even suggested that prospects be lined up for the apartment occupied by a man of 80—"for at that age you never can tell.")

Landlords, too, have supplied the bureau with offerings, obviously to beat rent ceilings. Typical values: Manhattan house, \$12,000 a year rent, fifteen-year lease, all alterations to be done by tenant; three-room furnished apartment, \$325 a month, plus a fat commission for the broker; six rooms on the fifteenth floor, \$7,500 a year; three rooms in a poor neighborhood, \$300 a month.

The bureau has persuaded a few auto dealers to dole out an occasional new car to a doctor. Since that doesn't ease a bad situation, it is appealing directly to the manufacturers.

In its attempt to find residences for veterans, the bureau first sent a mail questionnaire to hospitals. When that proved unproductive, it started a telephone campaign. This turned up a few openings. Then the bureau got in touch with every V.A. hospital in the country and was able to place a number of residents.

Appalled by conditions in New York, many a veteran seeks relocation in a smaller community. To help, the bureau first canvassed every county in the state. Results were not encouraging, so it tried writing to over-age physicians in communities of less than 10,000.

[PLEASE TURN TO PAGE 172]

Now! For greater convenience in prescribing—
DIETENE'S *Accessory Feeding*
 becomes **Meritene**

*Available in both plain
 and chocolate flavors*



Greater efficiency and convenience can now be yours in prescribing DIETENE's accessory feeding product by its new, easily-remembered name, "MERITENE".

MERITENE is the same product you have known and appreciated as DIETENE Accessory Feeding. The formula has not been changed in any respect; as MERITENE it continues to be a valuable high-protein supplement for use in difficult dietary cases.

However, you may now avoid any possible confusion with the companion product, DIETENE Reducing Supplement, by prescribing MERITENE.

Achieve highest patient co-operation now—by prescribing MERITENE, DIETENE's accessory feeding product.

R_x You will find MERITENE's high protein, rich vitamin and mineral content a distinct aid in assuring adequate nutrition for patients requiring special, high-protein gastro-intestinal, bland, pre-natal or post-operative diets. MERITENE is palatable, adaptable, easy to prepare and use.

THE DIETENE COMPANY

MINNEAPOLIS 15, MINNESOTA

Manufacturers of Meritene Accessory Feeding and Dietene Reducing Supplement

This brought a better response, and now a number of New Yorkers are practicing in small towns. In one case, reports the bureau, a veteran was nearing the end of his rope: no practice, no job, no future, and practically no money. Within a short time he was introduced to a suburban doctor who needed an assistant.

To find salaried positions, the bureau has written to insurance companies, banks, hotels, public utilities, air lines, steamship companies, railroads, and industrial concerns. Response generally has been poor, but the bureau has placed some men. In one instance, it had to convince a mail-order house employing 2,000 that an industrial physician would be a good investment.

The bureau is now building up a new clientele: civilian practitioners who want information on post-graduate courses, requirements for specialty boards, how to buy surplus Government property. But it still concentrates on veterans. "At the moment we are helping an entire family of four brothers," the bureau reports. "The first brother needed an office, which we helped him find after many weary months of searching. The second wanted a residence, which was also located after a good deal of effort. A few days ago the third returned from Europe and is looking for an internship. The fourth brother is still in Germany but we are starting to collect information on post-graduate courses and possible office space for him."

PROMPT ESTROGENIC ACTION

Schieffelin BENZESTROL

(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)



Menopausal symptoms and other conditions involving an estrogenic deficiency have been found to respond rapidly and favorably to this synthetic estrogen.

Schieffelin BENZESTROL, a non-stilbene compound, is a preparation of high estrogenic activity and has proved to be desirable because of its low incidence of untoward side effects.

Schieffelin BENZESTROL is available in tablets of 0.5, 1.0, 2.0 and 5.0 mg., in solution, in 10 cc. vials, 5.0 mg. per cc., and vaginal tablets of 0.5 mg. strength.



Schieffelin & Co.

20 COOPER SQUARE, NEW YORK 3, N.Y.
Pharmaceutical and Research Laboratories



ANNOUNCING

Meprane

3,4-bis-(*m*-methyl-*p*-propionoxyphenyl) hexane

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Economic estrogenic therapy is now available to physicians without the hazards of patient discomfort and imperfect relief of menopausal symptoms.

OUTSTANDING ADVANTAGES

- Relieves menopausal symptoms promptly.
- Restores sense of well-being.
- Unpleasant reactions virtually unknown.
- Exceptionally economical.

Comprehensive clinical studies in outstanding medical centers attest the estrogenic potency and clinical dependability of Meprane. Prompt relief of menopausal symptoms was reported in a large series of cases, patients usually experiencing partial remission of symptoms during the first days of treatment. Unpleasant reactions are virtually unknown.

DOSAGE: In the menopause, initial therapy—3 tablets daily; maintenance therapy—1 to 2 tablets daily.

PACKAGING: Boxes of 30 and 100, 1 mg. (1-65 gr.) tablets, individually wrapped. Literature and samples on request.

Meprane • **FOR MENOPAUSAL WELL-BEING**

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caffeine in coffee...



can drink delicious caffeine-free
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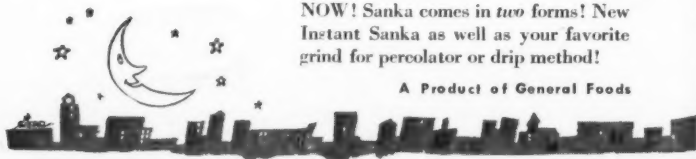
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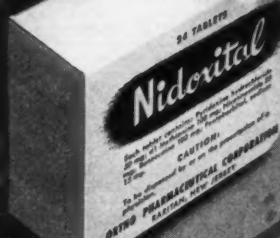
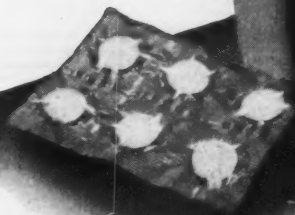
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ORTHO PRESENTS Nidoxital

FOR THE CONTROL OF
NAUSEA AND VOMITING
OF PREGNANCY



Formula: Each tablet contains
Benzocaine 100 mg
Pyridoxine hydrochloride 50 mg
Nicotinamide 50 mg
dl Methionine 100 mg
Pentobarbital sodium 10 mg

The average dose is one to two tablets 30 to 40 minutes before meals. Literature with full details available on request.

Nidoxital is a new preparation comprising five drugs combined into a single tablet for oral use. • The immediate relief which Nidoxital provides is apparently effected by a reduction (1) in the response of the esophagus, stomach and intestine to afferent stimuli; (2) in the sensitivity of the vomiting center; and (3) in the amplitude of gastric and

intestinal muscular contractions and peristalsis. • Over a longer term, the pyridoxine present in Nidoxital improves the ability of the liver and gall bladder to utilize unsaturated fats. Methionine provides

protection for the liver and enhances metabolic function. • Clinical trials have shown Nidoxital to be free of toxic reactions even in high dosage.



Ortho Pharmaceutical Corporation, Raritan, New Jersey

Makers of gynecic pharmaceuticals